			1 - For State Registrar	State of Marylan		artment of I		d Mental H	ygiene Reg. No	8 02501
R.	Physici	_	Decedent's Name (First, Middle, Last) LUCY LONG	BOYD				2. Date of D Month JAN	14 ^{Day} 200	3. Time of Death 8 10 • 07AM
	/Medic Examin	4 9	4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town,	or Location of D	eath	4c. County of	Death
		2	21311 Woodfiel				nersbui			GOMERY
25	Funeral Director		5. Social Security Number 6. Sex 1 1 1	7. Age (In yrs. I	ast birthday) Yrs.	Months Days		#rs. 8. Date of 8 (Month, 1) May	30,1930	0. Birthplace (State or Foreign Country) Virginia
V	D D		Usual Residence of Decedent 10a, State 10b. County	10c. Cit	, Town or Lo	cation				10d. Inside City Limits
	Manyis if eho	tor	MD Montgo	omery	Ga	ithers	ourg			1 ☐ Yes 2 📉 No
	with the	Direc	10e. Street and Number 21311 Woodfie	eld Road		10f. Zip Code	20882		10g. Citizen of What U.S	
36	i within 72 hours after death with the Maryland liene. r then "naturel", or items 23a or 28e-f ehow the Medical Examiner must be notilised at	y Funeral Director		2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of f Yes, specify Cut		? (Specify Yes or Nuerto Rican, etc.)	Black,	American Indian, White, etc. Black
21215-0036	n 72 hou "nature	Completed by	15. Decedent's Educa (Specify only highest grade	ation completed)	(Give	tent's Usual Occu kind of work done OO NOT use retire	during most of	working	16b. Kind of Busin	ness/Industry
212		omo	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		robiol			FLOL	ABS
	ould be filed Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) Ernest Long					_{Name (First, Midd} nnie Lai	le, Maiden Sumame) nbert	
Maryland	2 sh and and le m	F	19a. Informant's Name/Relationship (Typ						nber, City or Town, St	2, 0 0 0 -
	1 and Health tem 27		Felicia Elder	20b. P	lace of Dispo	sition (Name of	1	Date Date	20c. Location - Ci	er Spring, MD
nor	Ø O >		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			natory or other pla Grove (/19/08	Layton	sville,MD
Baltimore,	permit. Page Depertment of Important: If eny injury or		21. Signature of Funeral Service Licens	Levare						L HOME, P.A. le,MD 20850
1	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	eations that caused the deatle cause on each line. Phenon Due to (or as a conseq	d	er the mode of dy	ing, such as car	diac or respiratory	arrest,	Approximate Interval Between Onset and Death AUS
8760,	The law requires that the death certificate be executed as the has been signed by the attending physicien and page 2 should be detached for use as the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	ianda offi					
P.O. Box 68	at the death certifica by the attending phatached for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of degree of the second sec	death 3	Ectopic pregnand Other (specify)	су		23d. Date of Month	
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions cont	tributing to death but not res	ulting in the u	nderlying cause g	iven in Part I.		Yes 2 No 3	probably 4 □Unknown are autopsy findings available
Rec	The law sete has page 2 s	Completed	Diapeles					au	topsy priormed? des	or to completion of cause of ath? Yes 2 No
Vital	icien: T certificet rector, pa	BeC	25. Was case referred to medical examiner?					Death (Check onl	y one)	
of	ng Phys fter this ineral di	tion; To	1 Yes 2 No 27. Manner of Death t Natural 5 Pending 2 Accident Investigation	ospital: t ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Inj	ther: 4 Nursinury at ork? Yes 2 No	28d. Describ	esidence 6 Other e how injury occurred	
Division	5 분들 등	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	reet, factory, office	Э		(Street and Number Town, State)	or Rural Route Number,
	e Hospitel 24 hours 6 6 Funeral	edical (29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of my knower: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the vestigation, in my	time, date and p opinion, death o	place, and due to the control occurred at the time	ne cause(s) and manne, date and place, an	ner as stated. Indicate to the cause(s)
Ĩ,	To the within 2 To the complet	Me	29b. Signature and title of certifier	usko na	n. m.	29c. Licer	51916		29d. Date signed ((Month, Day, Year) 4, 2008
	(D		30 Name and address of person who cor	mpleted cause of death (Item	23a) (Type,	Print)	://a D	La 0 1	on Partie	H, 2008 He, MD 20852
		ate	31. Date filed (Month, Day, Year)	32. gistrar's Signa	////7	NOUKV	1/16 /1	NE, OTI	V, NOONVI	1.0,1119 40008
1	Regist	rar	JAN 16 ZUI	JO Balleto	J. De	MARIE !				

P.O. Box 68760, Division or Vital Records. Hospital or Attending Physician:

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I Director: Af
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To the Funeral Dire
completely filled in b

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and tive of certifier

🗁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

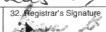
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W 6701 N. Charles ST TOWSON MD ZIZON

State Registrar

Medical

(Check only

31. Date filed (Month. Dav. Year) JAN 3 1





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 09,2008 Doris Stovold Corddry 12:25 P M Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** La Casa, LLC Assisted Living Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 TF 024-14-5456 84 **Director** May 13,1923 Maine Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notifled at Anne Arundel Annapolis 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 946 Schooner Circle 21401 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than the M Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health end Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Mones. Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry William Stovold Ida Bowton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Corddry/ Husband 946 Schooner Circle Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Depsis one week /Medical Due to (as a consequence of): Examiner Malnutritio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ementia attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 ☐ Other (specify) 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy certificate ha perform To the Hospital or Attending Physician: 25. Was case referred to nedical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Assisted Live 1 TYes 2 1 Ko 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / filled in by the f 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 P 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 01-10-2008

State Registrar 30. Name and address of person who comp

JAN 1 5 2008

ucinda 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ^M1^m/11/2008 1040 ам Ruth P. Crilly /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 9/30/1920 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Months 1 □ M 2 1 F 87 220-74-2924 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Shady Side 1 ☐ Yes 2 ☑ No Anne Arundel Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20764 USA 1123 Steamboat Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 21X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify þ Specify: 3₺Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lina Lee Whittington John S.W. Parks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1123 Steamboat Rd. Shady Side, MD Ginger Griffith Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 1/15/2008 James Cemetery Lothian, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service on Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician TRACT URISARY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Detal death 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) by the a 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has t e 2 s autopsy performe Yes page certificate the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes မ Inpatient 2 ER/Outpatient 3 DOA this After thi 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 If ying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14 D3903 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis, MD 21401 2001 Medical Pkwy. Dr. Mitchell, M.D. 31. Date filed (Month, Day, Year) egistrar's Signature State JAN 1 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** KEVIN P. CURLEY anuary /Medical cility Name (If not institution, give street and n 4b. City, Town, or Location of Death. 4c. County of Death Examiner NONE: 8. Date of Birth (Month, Day Year) APRIL 23, 1957 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F PENNSYLVANIA Yrs. 50 196-46-7388 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 X Yes 2 □ No HAVERIOWN Directo PENNSYLVANIA DELAWARE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 Is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be 19083 UNITED STATES 148 WOODBINE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. I □ Yes 2 X No f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 7 ealth and Mental Hygiene. n 27 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) TIMBER 12 FORKLIFT OPERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked c any Injury or other traumatic eventee. SARAH M. DOWNEY LOUIS J. CURLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 148 WOODBINE ROAD, HAVERTOWN, PENNSYLVANIA 19083 LOUIS J. CURLEY/BROTHER 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State CHESAPEAKE CREMATION JANUARY 14, 2008 1 ☐ Burial 2 XCremation 3 ☐ Removal from State STEVENSVILLE, MARYLAND 4 □ Donation 5 □ Other (Specify) CENTER 22. Name and Address of Facility FELLOWS, HELFENBETH & NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service Licenses Will E Hoon M00672 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau' e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-tran and to (or as a consequence P.O. Box 68760, physician Physician/Medical the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ briknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? res 2 12 No 1□ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the

29b. Signature and title of certifier

Registrar

and manner stated.

30 Name and address of person who completed cause of death (Item 23a)

			FOI	epartment of Health and M	lental Hygid	ene	0.0506
			1 - State Registrar	Certificate of Death	Reg	Now UUU	02506
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
*	- /Medic		David Hood Carey		January	10, 2008	
1	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
	Funeral		Collingswood Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	Rockville (day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgor 9. Bir	thplace (State or Foreign
	Director		525-64-2510 1⊠M 2□F 84 Yr	s. Months Days Hours Min.	(Month, Day,) Oct. 12,		ountry) MN •
de la	P.		Usual Residence of Decedent				Trail is on it is
	arylar show	ř	10a. State 10b. County 10c. City, Town of	r Location			10d. Inside City Limits 1 ☐ Yes 2☑ No
	the M 28a-f otifie	Director	Maryland Montgomery Brooke	eville 10f. Zip Code	100	g. Citizen of What C	
	with a or				100		,
	ns 23 mus	Funeral	3020 Holiday Drive 11. Marital Status 12. Was Decedent Ever in U.S.	20833 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	United S	erican Indian,
ပ္	after or iter	Fur	1 Never Married 28 Married Armed Forces? 1 Fyes, Give 1943— If Yes, Give	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, Whi	te, etc.
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1946	To res 20110 Specify.		Specify: W	nite
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121	within sne. than	dm	Elementary/Secondary (0-12) College (1-4or 5+)	ivil Engineer		ederal Go	zarnmant
d 2	filed Hygid	ပိ	17. Father's Name (<i>First, Middle, Last</i>)		First, Middle, Ma		vermment
lan	ld be ental ked o	To Be	William Nelson Carey		Marv He	elen Wad	2
Maryland	shou and M s mar			Mailing Address (Street and Number or Run			
Σ,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			O Holiday Drive, Bro			
Baltimore,	ges 1 If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State 20b. Place of Disposition 20b. Place of Disp	Disposition (Name of crematory or other place)	Date 20	0c. Location - City o	r Town, State
ţ	t. Pacternt:		1	litan Crematory 1/1			, Virginia
Bal	Departiment of the services of	-	21_Signature of Funeral Service Licensee	22. Name and Address of Facility De			VD 00077
			23a Part1 Enter the disease or complications that caused the death. Do no	10 East Deer Park D			
	Dharistan		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final			,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of	ung conces	~		
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	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	r			
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8760,	cate be executed oblysician and the burial-transit	al E	resulting in death) Last Due to (or as a consequence of	ı.			
687	physicate sthe	dical	d				
Box (eath certific attending p for use as	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of de	elivery
-	death certific e attending p d for use as	iclar	in the past 12 months? 1 Ves. 2 No. 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
P.0	t the by the ache	Physician/Med	9 ☐ Unknown		_		
	w requires that the s been signed by the should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.			to the cause of death?
ord	requir sen si nould				1 Yes	s 2□No 3□F	Probably 4 □Unknown
Sec	law as b	Completed			24a. Was an autopsy	/ prior to	autopsy findings available completion of cause of
alF					perform 1 Yes 2	ed? death? MNo 1 ☐ Ye	
ΖĦ		Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	Other	h (Check only one		
o	y Physer this eral di	٦: ح	27. Manner of Death 28a. Date of Injury 28b. Tir	ne of 28c. Injury at	28d. Describe hov	nce 6 □Other (Sp w injury occurred	есіту)
ion	Attending F r death. ector: After by the funer	atio	1 Matural 5 □ Pending (Month, Day Year) Inj 2 □ Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No			
Division or Vital Records,	or Attencafter death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stre		Rural Route Number,
	nital or Jus afte Iral Dir Iled in						
	Hosp 24 hou Fune stely fi	Medical	29a. Certifier (Check only one) 1				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral	Mec	and mainst states.	29c. License number	29	ld. Date signed (Moi	nth, Day, Year)
			1 557 JM MD	0006243	5	1/10/	2008
	12+1		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Pripit) A 2	10 111-	A4. ^	0-65
			30. Name and address of person who completed cause of death (Item 23a) (T 30. Name and address of person who completed cause of death (Item 23a) (T 31. Date filed (Month, Day, Year) 32. Registrar's Signature	tile links by Noc	Cuille	1111	(00)0
	Sta		31. Date filed (Month, Day, Year) JAN 15 2008 32 Tegistrar's Signature	Sugar 2			
	Regist	वा	Onit I I Loon Bright for				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1323 Melvin Joseph Caldwell 2008 /Medical County of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisbury f Under 1 Year If Unde 8. Date of Birth (Month, Day, Year)
July 22,1923 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1**X** M 2□ F Min 217-16-4890 84 Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. Count 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 5437 Loch Ness Terrace USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1943— 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White þ Specify. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Health Care Attorney is marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event; i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Thomas Caldwell Henrietta Thiess ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5437 Loch Ness Terrace, Salisbury, MD 21801 Melvin J. CAldwell, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 4 1 X Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery 1/16/2008 Beulah, Maryland 4 ☐ Donation — 5 ☐ Other (Specify) 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802 21. Signature of Funeral Service Liv Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gadse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final of his **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner NRUMON Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. the attending physician the for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9□Unknown 9 I Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform this certificate 2 **M**No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 12/27/07 1800 M 2 Accident 3 Suicide Grand within 24 hours after death To the Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide determined Wursing home 200 Cinc Are 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stateon C.Smo and title of certi License number 29d. Date signed (Month, Day, Year) 315 ME 14/08 pleted cause of death (Item 23a) (Type, Print) E. CARROLL 51.

State Registrar 31. Date filed (Month

NATIUS

			For State of Waryland		rtificate of	Death	Reg	. No 2008	02508
Ē	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Eleanor V. Cannatella			1	2. Date of Death Month January	fð, 2008	3. Time of Death 7:32P • M
	/Medio		4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital		4b. City, Town, o	r Location of Death		4c. County of Dea	George's
	Funeral Director		0,000	last birthday) 35 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Nov . 23,	9. Bir Vi°i	thplace (State or Foreign Cupty) 181nia
	Maryland t-f show fied at	tor	754.	y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 X No
	3a or 28a	al Direc	10e. Street and Number 11312 Cherry Hill Road,#102		10f. Zip Code 207	05	10	Citizen of What C United St	ountry? tates
036	be filed within 72 hours after death with the Maryland ntal Hyglene. 94 other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	lispanic Origin? (Spe an, Mexican, Puerto F Specify:		14. Race - Am Black, Whi	te, etc. White
21215-0036	/ithin 72 h ne. han "natu e Medical	mplete	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dece (Give life. Homen	_	eation during most of workin d)	g	sb. Kind of Business vn home	/Industry
_	0 = 0 =	To Be Completed by	17. Father's Name (First, Middle, Last) John Thorpe	Homen	iioke i	18. Mother's Name Virginia	(First, Middle, Ma		
Mary	nd 2 shou alth and N 27 Is mar ir traumat		19a. Informant's Name/Relationship (Type. Print) Richard G. Cannatella -son	19b. Mailii 11312	ng Address <i>(Street</i> 2 Cherry	and Number or Rural Hill Rd.,#	Route Number, 102 Bel	City or Town, State, tsville, I	zip Code) Maryland20705
Baitimore, Maryland	Pages 1 a nent of Hec int: If item iry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ropoli		atory 1/13	3/2008 A		Town, State , Virginia
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic es		21. Signature of Funeral Service Licensee	Dc	2. Name and Addre	ss of Facility Borgwardt r Mill Roa	Funeral	Home, PA	cyland 20705
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complicate s that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Heart Fail Due to (or as a conseq Chronic Others)	uence of):				*1	Approximate Interval Between Onset and Death
ů,	rificate be executed by physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence	ueroe <i>di)</i> :		01.029 2200			
68/6 0,	tificate be ig physici as the bu	dedical	d						
C. Box	death ce e attendir d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	uldeath 3[□Ectopic pregnanc □ Other <i>(specify)</i>	y		23d. Date of de Month	elivery Day Year
ecords, P.	requires that the een signed by th nould be detache	by	Part II. Other significant conditions contributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.		7.7	o the cause of death?
I	The la	Completed					24a. Was an autopsy perform	prior to	
VItal	Physician: this certific ral director,	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	FR/Outpatie	nt 3 X DOA Oth	26. Place of Death		ce 6 □Other (Spi	acifu)
lon or	nding Physician: th. : After this certifica s funeral director,	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation (Month, Day Year)	28b. Time o Injury	of 28c. Injur		8d. Describe how		Sury
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of injury - At h building, etc. (Specification)	ome, farm, str	reet, factory, office	2	8f. Location (Stre City or Town,	et and Number or F State)	lural Route Number,
	ne Hospit n 24 hours ne Funera	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knot one) 1 Medical Examiner: On the basis of examiner and manner stated.	wledge, deat ition and/or in	th occurred at the tinvestigation, in my	me, date and place, a opinion, death occurre	and due to the cau ed at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	withi Vorth	M	29b. Signature and title of certifier		29c. Licens	e number 7614298	29	d. Date signed (Mon	th, Day, Year)
	5		30. Name and address of person who completed cause of death (Iten Reshma Modi, D.O. 7474 Greenway	123a) (Type, / Cente	er Drive	Greenbelt,	Maryla	nd 20770	
	Sta Registr	_	31. Date filed (Month, Day, Year) JAN 1 6 2008 32. Agistrar's Signary	iture	parti				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 13, Edith Maureen Donohoe January 2008 9:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 217 Linden Avenue Edgewater Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 3/5/1930 Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🗓 F Director 579-34-8622 77 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified 1 ☐ Yes 2 X No Director Maryland | Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or idical Examiner must be 217 Linden Avenue 21037 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 💢 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo White Completed by 3

Widowed 4 □ Divorced nt of Health and Mental Hygiene.
If item 27 is marked other than "natu
or other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin Conley ဂ္ Edith Cecelia (unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen T. Donohoe/ Daughter 402 Lakeview Avenue, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Department o important: If any injury or 4 □ Donation 5 □ Other (Specify) Kalas Crematory 1/15/08 Edgewater, MD 21. Signatur of Funeral Service Livenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset and D CAD Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 423 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or irijury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by cete has been sig , page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification; To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 61-14-2008

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 1 5 2008

32 negistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Francis John Doyle Jr. 8:54 A Jan 14 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 ☐ F Months Days Hours Min 177-36-6329 61 Director Jan 25, 1946 Pennsylvania Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Anne Arundel Arnold 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21012 545 Bay Green Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black. White, etc. 1 Xi Yes 2 □ No If Yes, Give Year or Dates: Vietnam 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Steel Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis John Doyle Sr. Ruth Weidman P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traum once. 545 Bay Green Drive Arnold, Maryland 21012 Mary E. Doyle/ Wife Date 17, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan 🖰 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD MD Veterans Cemetery 2008 4 ☐ Donation 5 ☐ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral H 495 Gov. Ritchie Hwy, Severna Park, MD 21146 natur f Funeral Service P.A. Severna Park Funeral Home Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition resulting in death) **Physician** Una Cancer month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician use as t nding IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy atter for L in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ s been signe should be c Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of page death? 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical director 26. Place of Death (Check only on Medical Certification: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 ☐ Inpatient this funeral Manner of Peath 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Year) 5 Pending investigation Natural 2 Accident (Month, Day Injury Jospital S. 4 hours after des. 4 hours after des. 7 hours alter des. 4 hours after des. 4 hours after the first state of the fi 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the ...
within 24 hours a...
To the Funeral Direct 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D52830 MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road #300, Amaz lis, ND 2140

Registrar

31. Date filed (Month.

900 Bestaate

Pigistrar's Signature

werner JAN 1 5 2008

			For State Registrar	State of Marylan		artment of H rtificate of		nd Mental Hy	/giene	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	02511
	Physici		1. Decedent's Name (First, Middle, Last) Salvatore	J.	Doi	nato		2. Date of D Month January	Day	Year	3. Time of Death 11:00 A M
	/Medic Examin		4a. Facility Name (If not institution, give s 5801 Spe11 Road	treet and number)		4b. City, Town, o	r Location of		4c.	County of Death	
	Funeral Director		370-34-3409	M 2□ F 7. Age (In yrs. 77	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of B. (Month, C) Feb. 23	rth ay, Year) , 193	9. Birth Cou Wash	place (State or Foreign ington,DC
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Geo		y, Town or Lo	ecation					10d. Inside City Limits 1 ☐ Yes 2⁄(X)No
	with the	Directo	10e. Street and Number			10f. Zip Code				zen of What Cou	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show supplying or other traumatic event, the Medical Exacilizational be notified at ODEs.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 XYes 2 □ No Kor If Yes, Give Year or Dates: War	roon	20735 Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No		n? (Specify Yes or N Puerto Rican, etc.)	0-	USA 14. Race - Ameri Black, White, Specify: Wh:	
21215-0036	d within 72 ho giene. or than "naturi	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	dent's Usual Decup kind of work done DO NOT use retire ion Chief	during most d d)	of working		nd of Business/Ir	
Maryland	Mental Hygarked other	To Be C	17. Father's Name (First, Middle, Last) John B. Dona				Marg		iMisa		
, Mar	and 2 sho saith and n 27 is m		19a. Informant's Name/Relationship (Ty) Kathryn R. Donato	_				or Rural Route Num		r Town, State, Zi	p Code)
altimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	emetery, crer	osition (Name of matory or other pla Lion Ceme		Date /8/2008		cation - City or T	
Balt	permit. Departr Importe eny inji		21. Signature of Funeral Service License	ZIN.		2. Name and Addre 160 Oxon Hi		George P. Oxon Hill,			
	Physician /Medical Examiner	ner	23a. Part1. Enfer the disease, of complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	1.	ກ ໆ juence of):	er the mode of dyi		ardiac or respiratory	arrest.		Approximate Interval Between Onset and Death
Box 68/60,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	an/Medical Examiner	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	Due to (or as a consequence of pregns 1 □ Live birth 2 □ Feta	ancy	⊒Ectopic pregnanc	v			23d. Date of deliv	,
P.O. B	that the death cer ed by the attendin detached for use	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of o		Other (specify)				Month	Day Year
	w requires tha been signed I should be det	by	Part II. Other significant conditions cor	ntnbuting to death but not res	ulting in the u	nderlying cause gr	ven in Part I.		tobacco u]Yes 2[the cause of death?
Division of Vital Records,	: The law recete has be paga 2 she	Completed						24a. We aut per 1 🗆 Yes	opsy formed?	24b. Were aut prior to co death?	opsy findings available ompletion of cause of 2 No
	sician certifi irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐	EB/Outpot	nt 3□ DOA Ot	205	of Death <i>(Check only</i> sing Home 5, Re			2.1
lon of	Attending Physician: The r death. ector: After this certificete h by the funeral director, paga	ation: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju		28d. Describe	_		iry)
Divis	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, paga	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, sti	reet, factory, office			(Street an own, State		ral Route Number,
	n 24 hour n 24 hour he Funer pietely fill	Medical	2 Gertifier 1 Gertifying Physical (Check only one) 2 Medical Exami	nor: On the best of my kinds and manner stated.	wiedge, deat ation and/or in	r occurred at the livestigation, in my	me, date and opinion, death	placs, and due to the concurred at the time	a cause(s) a, date and	and manner as I place, and due	stat⊎u. to the cause(s)
		X	29b. Signature and title of certifier	}-		29c. Licen	se number 06480	10		e signed (Month	, Day, Year)
R	(20)		30. Name and address of person who co Bhavin Patel, M.D.				nton,	Md. 20735			
	Sta Regist		31. Date filed (Month, Day, Year) JAN 0 8 2008	32. Registrar's Sign	ature .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) DOPMAN 2008 TANICE 11:08A M JAN 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death NEW MARKET FREDERICK 10300 GAS HOUSE PIKE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 1 F 77 131-24-4502 MAY 29,1930 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits FREDERICK NEW MARKET 1 ✓ Yes 2 ☐ No MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21774 GAS HOUSE PIKE 10300 U5 4 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME HOME MAKE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HEIN WILLIAM ALICE CERKEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (DAU) JANE CLARK 10300 GAS HOUSE PIKE NEW MARKET MD. 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ALVERTO V VAT. COM 1-17-08 CALUENTON 22. Name and Address of Facility GARY L. ROLLINS FOURTH ITOIN E 21. Signature of Funeral Service Licensee gay 2. 110 WEST SOUTH ST FREDERICK MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 weeks Henotice Failure

Physician /Medical **Examiner**

physician and s the burial-trans

certificate has b rector, page 2 sl

ospital or Attending Physician: Ti hours after death. uneral Director: After this certificate ly filled in by the funeral director, pa

within 24 hours af

To the Funeral D

completely filled in To the Hospital

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a, State

Funeral

Director

28a-f show notified at

ms 23a or ?

ral", or items 2 Examiner mu

'natural",

Departmen of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the M-dical

death

filed within 72 hours after

Pages 1 and 2 should be

Saltimore, Maryland 21215-0036

Director

Funeral

Completed by

	resulting in death)	Due to (of as a consequence of): Advanced Breast Co	zu Cel	9 years
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of).		
dical Ex	resulting in death) Last	Due to (or as a consequence of):		
nysician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	23d. Date of de Month	livery Day Year
by P	Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	o the cause of death? robably 4 □Unknown
Completed			autopsy prior to performed? performed?	utopsy findings available completion of cause of
Re	25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)	
0	1 ☐ Yes 2 📆 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence 6 □Other (Spe	ecify)
ation:	27. Manner of Death 1 ■ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) Injury Work?	l. Describe how injury occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or R City or Town, State)	ural Route Number,
Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	niner: On the best of my knowledge, death occurred at the time, date and place, and niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner a at the time, date and place, and du	s stated. e to the cause(s)
M	29b. Signature and title of certifier	29c. License number D 4 186	G 29d. Date signed (Mon	th, Day, Year) 14, 2008
	gramme On ALL	completed cause of death (Item 23a) (Type, Print) Kunan Hudi	King and	1702

Registrar

31. Date filed (Month, Day, Year)

2008

			1- Stete Amend Item Registrar		ryland/Den er fh,g90	artment of 13,05/26/2 rtificate of	lealth and Death			02513
Ì	Physici /Medic		1. Decedent's Name (First, Middle, Last, John Di	ssek				2. Date of Deat Month	Day Year 21 200	3. Time of Death 8 \$ 24 AM
	Examir Funeral		4a. Facility Name (If not institution, give Harford Memorial 5. Social Security Number 6. Sec.	. Hospital	(In yrs. last birthday)		de Grac If Under 24 Hr Hours Mir	S. 8. Date of Birth	Year) C	
	Director		060-22-2496 Usuel Residence of Decedent 10a. State 10b. County		79 Yrs.			2/1/192	8 New	V York 10d. Inside City Limits
	he Maryla 182-f ehov	Director	MD Harfor		Belcamp)				1 ☐ Yes 2X No
	ath with the 23e or 2			Ct. Unit	202	10f. Zip Code 2101			0g. Citizen of What C	١.
5-0036	ors after de ei', or frem Executivez	by Funeral	11. Marital Status 1 Never Married AMMarried 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1√2 Yes 2 □ No If Yes, Give KO Year or Dates V		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 250No	ispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi SpecifyWhi	te, etc.
2	shouid be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "nature!", or iteme 23s or 28s-1 show imatic event; the Medical Exertime transite incillied at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	durina most of w	orking	16b. Kind of Business	
Maryland 21	a d a b y	To Be Co	17. Father's Name (First, Middle, Last) John Dissek, Sr.	4		tary		ame (First, Middle, I	U.S. Gover Maiden Sumame) Pryshliws	
_	d 2 au 7 io 17 io trect		19a. Informant's Name/Relationship (Ty Michael J. Dissek	rpe, Print) (Son)		ng Address (Street Bluebill		Rural Route Number	City or Town, State,	Zip Code) 21078
altimore,	permit. Peges 1 an Depertment of Heali Importent: if Item 2 eny injury or other QRCE.		20a. Method of Disposition 1 □ Burial 2 ☑ remation 3 □ F 4 □ Donation 5 □ Other (Specify)		20b. Place of Disponentery, cre R. A. Fer	matory or other plac			20c. Location - City or West Chest	
Balt	permit. Depertn Importe eny inju		21. Signature of Funeral Service Licens	chlose		2. Name and Addre		Funeral H land 210	ome, P.A. 01-3399	
	Physician /Medical		23a. Part1. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a. COP	he death. Do not en	ter the mode of dyir	ng, such as cardi	ac or respiratory arm	est,	Approximate Interval Between Onset and Death
68760,	ficate be executed with the physicien and with the burial-transit and the physician	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	consequence of):	ńs 				4 weeks
P.O. Box 6	The law requires that the death certific sie has been signed by the ettending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	Fetal death 3	□Ectopic pregnancy	,		23d. Date of de Month	elivery Day Year
	w requires that been signed by should be deta	þ	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the u	ınderlying cause gıv	en in Part I.	23e. Did tot		to the cause of death?
Division of Vital Records,	ysicien: The law re is certificete has ber director, pege 2 sho	Completed						24a. Was a autops perform	y prior to	
3	icien certifi rector	Be	25. Was case referred to medical examiner?	fospital:		at all DOA Oth	05	eath (Check only on		
ö	Phys this ral di	To To	1 ☐ Yes 2 No 27. Manner of Death	1 × In patien 28a. Date of Injury		III 30 DOX	4 Nutsing	7-	ence 6 Other (Special own injury occurred	ecify)
vision	To the Hospital or Attanding Physician: within 24 hours effer death. To the Funeral Director: Affer this certifica completely filled in by the funeral director,	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day	Year) Injury y - At home, farm, st	M 1 □	k?` Yes 2 □ No	28f. Location (St	reet and Number or F	Rural Route Number,
٥	To the Hospital or A within 24 hours effer To the Funeral Direct Completely filled in by		29a. Certifier To Certifying Phy	building, etc.	my knowledge, dear	th occurred at the tir	ne, date and place	ce, and due to the ca	ause(s) and manner a	is stated.
	the H in 24 the F spiete	edical	one)	and manner stat	ed.					
)	To Tool	Σ	29b. Signature and title of certifier	to a	mD	29c. Licens			9d. Date signed (Mon	nth, Day, Year)
-	+1		30. Name and address of person who co	Ries, MD		Print) urford M	lemoria	27 I Hospi	tal	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	's Signature	B				

		State of Maryland / Department of Health and Mer State of Phy &FH 68/6 2/04/08 JH 1- Registrar Certificate of Death	ntal Hygiene Reg. No	2008 02514
		1 Decedent's Name (First Middle Last) Reportanza Estela Sigaran de Vargas 2.	Date of Death Month Da	3. Time of Death
Physic /Med		79 91120	Jan 1	
Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death University of Maryland Medical Center Fathing c	40	c. County of Death
*		5 Social Security Number 6 Sex 7, Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8.	Date of Birth	9. Birthplace (State or Foreign
Funeral Director		Months Days Hours Min.	(Month, Day, Year eb. 4, 19	942 El Salvador
ъ		Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location		10d. Inside City Limits
arylaı show	7	10a. State 10b. County 10c. City, Town or Location		1 ☐ Yes 2 ☑ No
the M 28a-f notifie	Director	Maryland Carroll Taneytown 10e. Street and Number 10f. Zip Code	10g. C	itizen of What Country?
3a or		409 Clover Court 21787	E1	Salvador
Baltimore, IMaryland Z1Z13-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the M-dical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Liftyes, specify Cuban, Mexican, Puerlo Ric	y Yes or No- an, etc.)	 Race - American Indian, Black, White, etc.
after or Ite		1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No If Yes. Give 1 ☑ Yes 2 □ No Specify Salvado		Specify: White
bours tural;	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	16b.	Kind of Business/Industry
Z1Z15-UU36 d within 72 hours aff giene. er than "natural", or , the Medical Examil	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	I	,
d with giene rithan	E	4 Teacher		ucation
e file al Hyg I othe vent,	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (F		•
ylar	70	Habraan Sigaran Abraham Sigaran Angela F. 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural R		
Maryland d 2 should be file lith and Mental Hy 27 Is marked oth		Total mornian o reality rolls and ro		
ore, Ma es 1 and 2: of Health a fitem 27 is		Salvador Vargas/Husband 409 Clover Court, Tar 20a. Method of Disposition 20b. Place of Disposition (Name of Date	e20c.	MD 21787 Location - City or Town, State
altimore, rmit. Pages 1 a partment of Hee portant: If item y Injury or othe		xx land of Disposition xx land ponation 5 □ Other (Specify) 20a. Method of Disposition 3 Removal from State 4 □ Donation 5 □ Other (Specify) Cementerio General de 2008		ılutan, El Salvador
IIII	ă.	21 Signature of Funeral Service Licensee		
Departition of the pool of the		Francis J. Collins 1 500 University Blvd. 23a. Parl 1. Ent. the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or many control of the disease.	. W. Silv	dome Inc. ver Spring, MD 20901 Approximate
8760, ate be executed Examine hysician and the burial-transit	ical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Interval Between Onset and Death
Ords, P.O. BOX 68 requires that the death certificat neen signed by the attending phy hould be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify) ☐ Other (specify) ☐ 5 ☐ Other (specify) ☐ Other (specify) ☐ 5 ☐ Other (specify) ☐ Other (specify) ☐ 5 ☐ Other (specify) ☐ Other (specify) ☐ 5 ☐ Other (specify) ☐ Other (specify) ☐ 5 ☐ Other (specify) ☐ Other (specify) ☐ 5 ☐ Other (specify) ☐ 5 ☐ Other (specify) ☐ 5 ☐		23d. Date of delivery Month Day Year
dS, P.O. I	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death?
cords w require been sig	ed	Diabetes mellinis	1 Yes	2 No 3 Probably 4 Mnknown
Rec he law e has b	ompleted	Hypothyroidism	24a. Was an autopsy performed 1 Yes 2 ☑	
Vital F sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	Check only one)	
or Vita Physician: r this certific	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other, 4 ☐ Nursing Home	e 5 Residence	6 Other (Specify)
T gc an	on:	1 Matural 5 Pending (Month, Day Year) Injury Work?	id. Describe flow ii	ijary occurred
Division of or Attending after death. Director: After	Certification:	2 Accident	Rf. Location (Street City or Town, St	and Number or Rural Route Number, ale)
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, are considered in the construction of the property of the pr	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within To the compl	Me	29b. Signature and title of gother P19694		Date signed (Month, Day, Year) Jon 17, 2008
3		30. Name and a viress of person who completed cause of death (Item 23a) (Type, Print)	R U	MO 71201
		31. Date filed (Morth, Day, Year) 2. Registrar's Signature	Dalamore	. INU LIWI
Regi	State strar	30. Name and a viess of person who completed cause of death (Item 23a) (Type, Print) Milip (. Diffmar MD 22 South Greene Street) 31. Date filed (Month, Day, Year) JAN 15 2008 Manual Manua		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** January 10, 2008 6:05 Dassen Antonius /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 11610 Game Preserve Road Gaithersburg Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days **Funeral** Months 1 X M 2 □ F 80 Vrs 17, Jan. 1927 Netherlands 577-48-4116 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Gaithersburg Director Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Netherlands 20878 11610 Game Preserve Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 No
If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married White 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Bricklaying Contractor permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hyg
Important: If Item 27 is marked other
any injury or other traumatic event, is 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Janssen Laurentius Dassen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11610 Game Preserve Road, Gaithersburg, MD 20878 Jane A. Dassen / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Boyd's Presbyterian
Church Cemetery 20c. Location - City or Town, State Date 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State January 14 Boyds, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furreral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 IRACI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death of the Head and Not Immediate Cause (Final Squamous cell carcinoma Physician disease or condition resulting in death) /Medical Def (or as a consequence of): Examiner Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-tran Due to (or as a consequence of) physician Physician/Medical the as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **₽** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 No 1 ☐ Yes certificate 1□ Yes 26. Place of Death Check onl o 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3□ DOA 1 ☐ Yes 2 this 27. Manu of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred funeral Certification: After 1 (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

that the death certificate be executed Box 68760 P.O. Records, Division or Vital

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Hospital or Attending Pl 24 hours after death. Funeral Director: After the filled in by the To the Hospital within 24 hours a To the Funeral C

Medical

State

Registrar

Hughuel 31. Date filed (Month, Day, Year) JAN 15 2008

29b. Signature and title of certifier

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 468 Themas Johnson Drive Frederick, MD 21107 Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

	1	For State Registrar	ate of Maryla		oartment of Fertificate of		•	giene Reg. No. 2 1 1 8	0.2516
Physiciar /Medica	1	1. Decedent's Name (First, Middle, Last) MARIBETH R	. DEMPS	SEY			2. Date of De	But 00 0	3. Time of Death 3:50 Рм
Examine		4a. Facility Name (If not institution, give street at 4521 East-West	Highway,			r Location of D hesda			th CGOMERY
Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In y	rs. last birthda Yrs.	y) If Under 1 Year Months Days		lin. 8. Date of Bir (Month, Da Sept.	th 2 ^Y ea ^r , 1955	thplace (State or Foreign ountry) W • VA
Laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural" or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	10101	Usual Residence of Decedent 10a. State 10b. County MD Montgome 10e. Street and Number	ry		Bethesda 10f. Zip Code			10g. Citizen of What Co	-
be filed within 72 hours after death with the Marylar ntal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Lallelal	1 Never Married 2 Married 1 F	as Decedent Ever in med Forces? Yes 2 No es, Give		2 (B. Was Decedent of H If Yes, specify Cub	0814 Hispanic Origin? an, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	U.S. A 14. Race - Ame Black, Whit	erican Indian, te, etc.
Maryland 21215-0036 to 2 should be filed within 72 hours at Ith and Mental Hygiene. 27 is marked other than "natural", or r traumatic event, the Medical Exami	a paidill	15. Decedent's Education (Specify only highest grade comp	oleted)	16a. Dec	redent's Usual Occup re kind of work done DO NOT use retire Homem	during most of d)	working	16b. Kind of Business	
rland 2	2000	17. Father's Name (First, Middle, Last) Edward V. Berard	1		пошеш	18. Mother's I	Name (First, Middle,		
5 5 5 5 5 5		19a. Informant's Name/Relationship (Type. Pro Michael Dempsey	(Son)	17	822 Bueh	ler Ro		er, City or Town, State, A	
Baltimore, I permit. Pages 1 and Department of Healt Important: If item 2; any Injury or other?	-	20a. Method of Disposition 1 ☐ Burial 2 ☆ Oremation 3 ☐ Remove 4 ☐ Doynation 5 ☐ Other (Specify)	ai irom State	iverd	position (Name of rematory or other plant ale Pk C	re 1-	Date 14-2008	20c. Location - City or Riverdal	e, MD
Departiment of the policy of t	-	21. Signal re of Funeral Servic Lense 23. Part1. Enter the disease, or complication	raussed the de	A	246 N. W	ashing	ton St,	Rockville	HOME, P.A. ,MD 20850 Approximate
Physician /Medical		shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	se on each line.	rovasc	cular Acc		dia of respiratory a	most,	Interval Between Onset and Death
cate be executed by physician and the burial-transit and the burial-	LYB	Cause (Disease or injury that initiated events c.	Due to (or as a cons				-		
ecords, P.O. Box 68/60, law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit moted by Dhysician Medical Examin	yardanymean	in the past 12 months?	res, outcome pf pred Live birth 2 F Pregnant at time of Unknown	etal death 3	i⊟Ectopic pregnanc ☐ Other (specify)	у		23d. Date of de Month	livery Day Year
w requires that is been signed be should be detailed by Dries of the property	2	Part II. Other significant conditions contributi	ng to death but not r	esulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use contribute to	o the cause of death?
The The page	noid line						24a. Was autop perfo		utopsy findings available completion of cause of
ج القاق الح القاق الم	2	25. Was case referred to medical examiner? 1 Yes YNo Hospita 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	l: 1 ☐ Inpatient 2 a. Date of Injury (Month, Day Year)	28b. Time	of 28c. Inju	er: 4 🗆 Nursin		dence 6 Other (Spe	ocify)
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral		4 Homicide	. Place of injury - At building, etc. (Spe	ecify)			City or Tou		
To the Hospi within 24 hou To the Fune completely fil			To the best of my length of the basis of examined manner stated.	knowledge, de ination and/or	ath occurred at the ti investigation, in my of 29c. Licens	opinion, death o	occurred at the time,	date and place, and du	e to the cause(s)
5 with		29b. Signature and title of cartifier			P 317			Jan. 14,	2008
		30. Name and address of person who complete Herbert M. Jua	rbe, M.	D. 80	06 W. Di	amond	Avem #3	10,Gaithe	20877 rsburg,MD
State Registrar		31. Date filed (Month, Day, Year) JAN 1 6 2008	32 Registrar's Sig	S A	rester				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 8:40 A M 2008 11, Leonard Forman Jan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Months Hours 1⊠M 2□F Yrs. Director New York 20, 1917 117-01-4984 90 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 X Yes 2 No Directo MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15101 Interlachen Drive 20906 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Aryes 2 No Navy If Yes, Give WWTT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 Narried 1 ☐ Yes 2 No Specify WWII Specify: 3 Widowed 4 Divorced Year or Dates: White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Patent Examiner U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be Morris Forman Rose Yampolsky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silver Spring, MD 20906 Sylvia M. Forman - Wife 15101 Interlachen Dr. #409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount<u>Lebanon</u> 1/13/2008 Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility
Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused try death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lin Immediate Cause (Final Physician Subdural Hematoma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Atrial fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Examiner Due to (or as e consequence death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 3d. Date of delivery 3 ☐ Ectobic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death Month Year Day ed by the a detached f ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> page 2 should be 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings evailable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 2**X** No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify Hospice 1 ∑ Yes 2 □ No P 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 5 | Pending investigation Unkn. P M 1 ☐ Yes 2 ☑ No 2 X Accident 1/5/08 Patient fell at home in bathroom To the Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ryral Route Number, City or Town, State) 15101 Interlachen Dr. 4 Homicide At home Silver Spring, MD 20906 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check or one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m D0064615 January 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MDGenevieve Anne Wroblewski, 1355 Piccard Drive Rockville, MD 20850 31. Date filed (Month, Day, Year) Registrar's Signature State 15 2008 JAN Registrar

DHMH 17 Rev 1/2001

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 49a M 2008 lanuar Lillie Mae G1enn /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Doctor's Community Hospital Prince Georges Lanham If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🔀 F 01/09/1920 South Carolina Director 87 578-24-1738 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Directo DC Washington within 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; or items 23a any Injury or other traumatic event, the Medical Examiner must b Funeral 4121 18th Street, N.E. 20018 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Specify ģ 3 Hidowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Biological Lab Tech. Healthcare/Medical 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Smith Robinson Queen Ester Dean c 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9302 Alcona Street Lanham, MD 20706 Patricia Copelin/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 01/12/2008 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Funeral Service Licensee Louga Montgoney. 3401 Bladensburg Road Brentwood, MD 20722 23a. Part1. 5 ter the dhease, ir compilations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a been signed the should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has t autopsy performed? Yes 2N No 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 R/Outpatient 3 DOA 1 Inpatient မ 27. Manner of Deat 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? Injury (Month, Day Year) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO61131 and address of person who completed cause of leath (Item 23a) (Type, Print) Good Lick Road, Lanvary, MD 20700

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 8 2008

JAN 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Lardi Thomas Hav	1	ns Si - For State legistrar	ate of M	1aryland	/ Depart	ment of ficate of		and	Menta	al Hygi		g. N o.	200	8 02	51
Physiciar Medical Examin	1/	1. Decedent's Name (First, Midd	le,Last) Hawk	cins						2. E	Date of Death Month anuary 22	Day 2008	Year	3. Time of Death 2100 hrs	
*		4a. Facility Name (if not institution	on, give stree	et and number	r)		4b. City, Tov				aridary 22	4c. Co	ounty of Deat		
		7430 Calder Drive 5. Social Security Number	6. Sex	Ι 7 Δ	ge (In yrs. last	hirthday)	Capitol If Under			24Hrs. 8.	Date of Birt		ce Georg	e'S rthplace (State or _	-
Funeral Director		220-94-3346	1X M	1 7	3 4	Yrs	Months	Days	Hours	Min.	Feb.1	1,19	73 Forei	yn Wash. D	C
any	-	Usual Residence of Decedent			10c City To	own or Locat	ion							10d. Inside City L	imits
* .		Md. 10b. County P.G.			Capi	tol I	Heigh	ts						1X Yes 2	No
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MD 21 d 2 should the the and Mer n 27 is mar	٩	19a. Informant's Name/Relation Bernice All			il.								or Town, Stat Ieight	e, Zip Code) SMd 2074	. 3
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other transmatic event, the Medical Examiner must be notified at once.	Ī	20a. Method of Disposition 1 X Burial 2 Crematic 4 Donation 5 Other S	_	emoval from S	State FOI	ace of Disposematory or ot	sition (Name her place) NCOLI	of cem			1,08	I	ntwoo	r Town, State	
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Physician / / / / / / / / / / / / / / / / / / /	1	23a Part I. Enter the disease, of failure. List only one cause			ed the death. D	Do not enter t	he mode of	dying, s	such as ca	rdiac or res	spiratory arr	est, shock	, or heart	Approximate In Between Onse	
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Division Bospital or Attendir 24 hours after death. Fruneral Director: A	Certification:	3 Suicide 6 Co	nd not be	28e. Place of (Specify)	Injury - At hor	ne, farm, stre	eet, factory,	office bu	uilding, etc	unk 28	f. Location (or Town,	Street and State) U D	Number or I	Rural Route Numbe	r, City
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	State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2008 02520										
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أسمد	6		Gilchrist Center			- 1- 11111-1- 1		Towson If Under 24 Hrs.	8. Date of Birth		timore
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F		s. last birthday) 2 Yrs.	Months Days	Hours Min.	(Month, Day,	Year) 9.1	Birthplace (State or Foreign Country)
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	and w		10a. State 10b. County		10c. C	City, Town or Lo	ocation				10d. Inside City Limits
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	the 128a-	Director	Maryland He	Jward			10f. Zip Code	COTUMDIA	10	g. Citizen of What	Country?
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	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	1 ☐ Never Married 2 ☐ Marri	Armed F			Was Decedent of H If Yes, specify Cuba		Rican, etc.)	Black, W	hite, etc.
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212	with piene	E	8	College	(1-40/ 5+)		Chef			Priv	ate Family
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	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. It health and mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Theodosia Smith	- Daughter		1030	Cresthaven	Drive, Silv	ver Spring.	Maryland	20904
ā,	s 1 a f Hea item othe		20a. Method of Disposition		1	Place of Dispo	osition (Name of ematory or other place	na)	Date 2	20c. Location - City	or Town, State
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Baltimore,			21. Signature of Funeral Service		1	2	2. Name and Addre	ss of Facility		,	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 115 SAM Januar 16,2008 VICKY LYNN HIGGS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital attasto lemorial Talbo Easton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours 1 M 2 XF MARYLAND 212-72-1874 1966 DEC. 13, Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Funeral Director **OUEEN ANNE** CHURCH HILL 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 318 CHURCH HILL ROAD 21623 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 M Married ş 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 NURSE NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES THOMPSON DALE MORGAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 CHURCH HILL ROAD, CHURCH HILL, MD 21623 BRYAN HIGGS/ HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 1-17-2008 STEVENSVILLE, MD 4 Donation 5 Dother (Specify) CENTER 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic Break disease or condition resulting in death) Years Due to (or as a consequence of) Congulaire Heart Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Malignant Honetre Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 🗆 Yes 2 🖼 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation (Month, Day Year) Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

within 24 hours a To the State

Funeral

Director

r 28a-f show notified at

7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be i

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permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trauonce.

Physician

Examiner

/Medical

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Baltimore.

P.O. Box 68760 death certificate be

Division or Vital Records.

Registra

31. Date filed (Month, Day, Year) 1 7 2008

KOLLI

Name

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32. Reilstrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2195

WASHINGTON

D 66441

STREET, EASTON, MD 21601

January 16 2008

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 02522 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23^{Day} Month Physician 2008 Michael Howard James Jan. 20:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 12801 Growdenvale Dr. NE Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F Colorado Director 226-46-9993 70 2, 1938 Jan. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Middle at Examiner mines any longe. 10c. City, Town or Location 10a. State 10d. Inside City Limits MD 1 ☐ Yes 2 🔀 No Allegany Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12801 Growdenvale Dr. NE 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No 1 Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2X Married White 1 ☐ Yes 2 X No Specify Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donnelly Trent James Cleo (Simmons) James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 12801 Growdenvale Dr. NE, Cumberland, MD 21502 Lorraine James 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1x Burial 2 □ Cremation 3 □ Removal from State Jan 26,2008 Falls Church, VA Oakwood Cemetery 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Hafer Funeral Service, PA 1302 National Hwy., LaVale, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final cr husi Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ten diserse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Tyes 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 🗌 No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramaditya Poonai, 924 Seton Dr., Cumberland, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AN 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 0150 M 2008 Janua Christopher Johnson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wask If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days 1 ☑ M 2 ☐ F Director 50 Dec, 26, 1957 George, 061-50-7896 St. Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊈Yes 2 No Director Maryland Prince Georges Ft. Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 3 edical Examiner must be n 20744 7511 Glade Dr. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: or than "natur the Medical B Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other tt any Injury or other traumatic event, the <u>Auto Mechanic</u> Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pernice Brown David Johnson, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9011 Cameron Ct. Clinton, Md. 20735 Pernice Johnson / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Jan.10,2008 4 Donation 5 Dother (Specify) Resurrection Clinton, Md. 21. Signature of Funeral Service Lensee Name and Address of Facility Alexander S. Pope P.A. 5538 Marlboro Pike/Forestville, Md. 01010 23a. Part 1 There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atheroscherotic Heart Dis & CardioVasan **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1, Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural in 24 hours arrende Funeral Director: Afrendetely filled in by the funeral organization of the funeral filled in by the f 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide

Division or Vital Records, P.O. Box 68760. av

Maryland 21215-0036

Baltimore,

Medical npletely the 2

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person wire completed cause of death (Item 23a) (Type, Print)

3001 filed (Month, Day, Year) 2008

JAN 08 Registrar

29a. Certifier

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** January 11, Ying Kwong 11:30p 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Olney Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days N 2 □ F 215-13-9837 73 Director 28, 1934 Jan. Hong Kong Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2k No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4114 Heathfield Road 20853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💹 No Specify δ Speciasian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Interior Designer Home Decorating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kwong Kai Ming Mak Wan Chin 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Siu Chui Kwong/Wife 4114 Heathfield Road, Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2008 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA WEEKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, RIGHT YEMITHORAX HUPOPLASIA 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an PULMONALG PAROXISMAL autopsy perform certificate FIBRILLATION 2 **N**lo 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Atter (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ours after death. neral Director: A filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined To the Hospital within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

(Check only one)

29b. Signature and title of certifier

STREET # 500 10605 COMCORD 31. Date filed (Month, Day, Year) JAN 1.5 2008 32 Registrar's Signature

Dr. Lilute Heinz - Pomilore

KENSINGTON, MD 20835

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DK . LIBUSE HENZ-MOMCILOVIC

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0058542

29d. Date signed (Month, Day, Year) JAHUARY 12, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Phyllis Hansen Kindley 10, 2008 January 6:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 415 Russell Avenue, #1102 Gaithersburg Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 K F Director 577-58-3003 102 1905 July 5, Indiana Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 □ No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 415 Russell Avenue #1102 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 4 Housewife Humanitarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Burton Hansen Mary Antoinette Duncan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Lee Colglazier (Son) 6 Moulton Drive, Londonderry, NH 03053-4000 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit, Pages
Department of I
Important: If its
any Injury or o 1 ☐ Buria! 2X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 1/11/08 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, Maryland 20877 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1☐ Yes 2☒ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Peripheral Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy 1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 Yes 2X No ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide

certificate be executed Box 68760 P.0. Records, Division or Vital

physician and s the burial-trans as attending p for use as signed by the a d be detached f certificate has been si rector, page 2 should funeral director, After this spital or Attendi nours after death. neral Director: A / filled in by the fu death. To the Hospital or within 24 hours af To the Funeral D

ral", or items 23a or 28a-f show Examiner must be notified at

"natural", the Medical

Is marked other than

item 27 I

filed within 72 hours after (Hygiene.

should be fund Mental I

Pages 1

Baltimore, Maryland 21215-0036

Medical

State Registrar

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature a 29d. Date signed (Month. Dav. Year) nd title of certifier

D19294

January 11, 2008

30. Name and address of person who completed cause of death (item 23a) (Type, Pnnt)

911 Russell Avenue, Gaithersburg, MD 20879 . Melnick, M.D.

31. Date filed (Month, Day, Year)

JAN 15 2008

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		tificate of D			Reg. No.	008	0.2	526
	Physici		Decedent's Name (First, Middle, Last) Edward Lawson				2. Date of De Month Januar	Day	2008	3. Time of 9:50	Death P M
	/Medio		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center		4b. City, Town, or l	Location of Death Annapoli	1	4c. Cour	nty of Death nne Ar		
	Funeral Director		5. Social Security Number 214–28–3994	birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 2	y, Year)	9. Birthp Coun Ma	olace (State o ntry) ryland	r Foreign
	ne Maryland Ba-f show ptified at	Director	Maryland Anne Arundel 10c. City, To	own or Loc	Edg	ewater				0d. Inside Cit	
	th with the 23a or 2 ust be no		671 Loch Haven Road		10f. Zip Code 21	037	:	10g. Citizen d	S.A.	try?	
2-003p	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes, Give Year or Dates:	13. W	Vas Decedent of His Yes, specify Cubar □ Yes 2☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. R B	lace - America Black, White, of Cify: White		
7-61717	d within 72 h giene. er than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give k life. D	ent's Usual Occupa kind of work done du 10 NOT use retired) Iruck Dri	uring most of work	sing		Business/Ind	,	
/land	2 should be filed of and Mental Hygie I s marked other raumatic event, the	To Be C	17. Father's Name (<i>First, Middle, Last</i>) John Lawson			18. Mother's Nam Eliza	e (First, Middle beth Je		ame)		
, mar,	1 and 2 sho Health and I em 27 Is ma other trauma		Rose Marie Lawson/wife	571 Lc	g Address <i>(Street ai</i> och Haven	Road E					,
IIMore	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		4 Donation 5 Other (Specify)	rest	ition (Name of latery or other place Mem. Gard	dens 1/1	7 7 7 7 7 7 7 7 7	Annar	n-City or To	Maryl	
Da	Depar Impor any In		21. Signature of Funeral Service Licensee	147	Name and Address 7 Duke of	Glouces	hn M. T. ter St.	aylor I , Annap	unera polis,	MD 21	401
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	IUI		, such as cardiac	or respiratory a	rrest,		Approximate Interval Bett Onset and I	
	Examiner	Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	PATT	44					5 yes	cui_
oo,	certificate be executed ding physician and ise as the burial-transit	al Examiner	Cause (Disease or Injury that initiated events resulting in death) Last c. CORONALY Due to (or as a consequence of the control of the contr	ce of):	TERY D	USEAS	Ğ			5 year	urs arc
00/00 X		/Medical	IF FEMALE: 230 If was outcome of programme.		<u>cci ion</u>					390	
.O.	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. The within 24 hours after death. To the tuneral Directors. After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes → No 9 ☐ Unknown	ath 3□E	Ectopic pregnancy Other (specify)				Date of delive Month		Year
ecords, r	equires tha en signed ould be det	ğ	Part II. Other significant conditions contributing to death but not resulting Hypertension	g in the und	derlying cause giver	n in Part I.		obacco use co Yes 2□ No			/
ו שבכנ	The law recate has be page 2 sho	Completed					24a. Was auto perfo 1□ Yes		b. Were autop prior to condeath? 1 \(\text{Yes}	psy findings mpletion of ca 2 12/2/No	available ause of
VICAL	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{ID} \text{No} \) Hospital: 1 \(\text{Inpatient} \) 1 \(\text{Inpatient} \)	Outpatient	3 DOA Other	26. Place of Deat	th <i>(Check only o</i> ome 5 ☐ Resi		Other (Specifi	v)	
מוסוו סו	tending Ph sath. or: After th		1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	b. Time of Injury	28c. Injury Work? M 1 1 Y	at ? es 2 □ No	28d. Describe	how injury occ	urred		
	vital or Att urs after de rral Direct	Certification:	4 Homicide determined building, etc. (Specify)				28f. Location (City or To	vn, State)			iber,
	he Hosp in 24 hou he Fune pletely fi	Medical	29a. Certifier (Check only one) 1	dge, death and/or inve	estigation, in my op	e, date and place, inion, death occu	, and due to the rred at the time,	cause(s) and date and plac	manner as st e, and due to	tated. the cause(s	3)
	· // v (∑ (,)	29b. Signature and title of certifler	W	29c. License		,	29d. Date sign			8
	N. Com		30. Name and address of person who completed cause of death (to) 23a ALVIN S. MADARANG	a) (Type, P	Dan	MARK I	DR, S	TE 12	8;G	lenB	ume
	Sta Registr	ar	31. Date filed (Month, Day, Year) JAN 1 5 2008 32. Rejistrar's Signature								
DHM	MH 17 Rev 1/2	001									

Division or Vital Records. P.O. Box 68760

Baltimore, Maryland 21215-0036

s after dec.

within 24 hours a Medical the

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

6 Could not be determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

Daniel

29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. 115 Sallitt Drive, Suite & Stevensville, MD 21666 32. Digistra's Signature J. Konick, M.D.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) JAN 1 5 2008

			State	State of Ma	ryland.		rtment <i>tificate</i>				iene eg. No. 2 A l	10	00520
п	2 (Registrar 1. Decedent's Name (First, Middle, Last)							2. Date of Deat	h	<u> </u>	3. Time of Death
	Physicia /Medic		Ida Mae Hazel I	opez						January	6 200	8	3:39 A M
	Examin		4a. Facility Name (If not institution, give str	eet and number)			4b. City,	Town, or	Location of Death		4c. County of		
7			Talbot Hospice	1 - 1			If Under	East	ON If Under 24 Hrs.	O Data of Birth	Talk		(0)
	Funeral		5. Social Security Number 6. Sex	7. Age ⊿ 2 💢 F	(In yrs. last	Yrs.	Months	Days	Hours Min.	8. Date of Birth (Month, Day, May 19,	Year) 1928	Coul Mar	place (State or Foreign ntry) yland
	Director		Usual Residence of Decedent		19					racy 10,	1,720		y raise
	yland now at		10a. State 10b. County		10c. City, T	own or Loc	ation					1	0d. Inside City Limits
	e Mar la-f sl	ctor	MD Queen Ann	ie		Cheste	er						1 □ Yes 2 No
	or 28	Dire	10e. Street and Number				10f. Zip			1	0g. Citizen of Wh		ntry?
	within 72 hours after death with the Maryland ene. than "hatural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral Director	29-A Queen Mary C	と . 2. Was Decedent E	vor in II C	12 W	las Docod	216		ocify Vos or No-	14. Race		can Indian.
_	ter de item	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 12	Armed Forces? 1 ☐ Yes 2 ☒ No					spanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)	Black,	White,	etc.
50	urs af al', or Exam	þ	3 Midowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2	X No	Specify:		Specify:	Whi	te
215-0036	72 ho natur lical B	Completed	15. Decedent's Educa	tion completed)		16a. Decede	and of wor	k done d	lurina most of work	ing I	16b. Kind of Busi	ness/In	dustry
7	rithin ne. han " e Med	du l	Elementary/Secondary (0-12)	College (1-4or 5+	+)		O NOT us				Publish	ina	
7	iled w Hygie ther th	Ŝ	17. Father's Name (First, Middle, Last)			Rece	∋ptio		18. Mother's Name	e (First, Middle, I			
yland	d be i	o Be	Otis Faulkner						Anna B	rooks			
<u></u>	shoul nd Me mark	은	19a. Informant's Name/Relationship (Type	e. Print)		19b. Mailing	g Address	(Street a	and Number or Run		r, City or Town, S	tate, Zij	Code)
Z Z	and 2 alth a 27 is er tra		Patricia A. Beville	e / daugh	ter	515 S	kippe	r Ct	. Che	ster, MD	21619)	
ore,	of He of He fitem		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re	moval from State	cem	e of Dispos netery, crem	atorý or o	ther place	e) ¦		20c. Location - C	ity or T	own, State
Ĕ	Pag ment ant: 1 jury o		4 ☐ Donation 5 ☐ Other (Specify)		Metr				tory 01/0		Alexand		, VA.
Baitimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.		21. Signature of Funeral Service Licenses	·		- 1					eral Hor		715
	B B E @ 0		23a Part 1 Enter the disease or complic	ations that caused	the death				ain Hwy.		e, MD.	20	715 Approximate Interval Between
		5 1	23a. Part1. Enter the disease, or complications, or heart failure. List only one	P			4		FAIL		501,		Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a	UGES a consequer		610	PARCI	TATIL	4100		+	YEARS
	Examiner			240 10 (01 40 4	a donos que								
	7	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequer	nce of):							
	ecute ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a		of):							
ρĊ,	death certificate be executed e attending physician and d for use as the burial-transit	al E	resulting in death) East	Due to (or as a	a consequer	nce or):							
28/60	icate physi s the l	dical	d.									1	
BOX	certif nding use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome p							23d. Date	of deliv	rery
ň	death	iciai	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 2 4□Pregnant at			Ectopic pr Other (sp				Mon	th	Day Year
J Ö	the y th	hys	9 Unknown	9∐Unknown									
	The law requires that the death certifite has been signed by the attending agge 2 should be detached for use as	by F	Part II. Other significant conditions cont	ributing to death bu	ıt not resulti	ng in the un	derlying c	ause give	en in Part I.				the cause of death? bably 4 □Unknown
Records,	requii een s hould	ted											
ခို	m co oi	Completed								24a. Was a autops perfor	sy pr	ere aut ior to co eath?	opsy findings available ompletion of cause of
_			OF Man and a section							1□ Yes	2 40 1	Yes	2 NO
Vital	sician: certific irector,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatier	nt 2 TiFE	R/Outpatient	: 3 □ DC	A Othe	26. Place of Deat			(Space	fy)Hospice
o	g Phys er this eral di	⊢	27. Mann Death	28a. Date of Injur (Month, Day	y 2	8b. Time of Injury		8c. Injury Work			ow injury occurre		,,,,1,00,5100
Division	tending Peath. tor: After I	atio	1	(Worth, Day	reary	mjury	М		Yes 2 □ No				
<u> </u>	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju building, etc	ry - At home. (Specify)	e, farm, stre	et, factory	, office		28f. Location (S City or Tow		r or Rui	al Route Number,
	e Hospital or At 24 hours after d e Funeral Direc letely filled in by			sian. To the best o	of more transmit			at the tip	ne date and place	and due to the	course(s) and mar	202.00	atated.
	24 ho 24 ho Fune etely f	Medical	29a. Certifier 1	er: On the basis of and manner sta	examinatio	n and/or inv	estigation	, in my o	pinion, death occur	red at the time, o	date and place, a	nd due	to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	Me	29b. Signature and title of certifier				290	c. License	e number	2	29d. Date signed	(Month	, Day, Year)
	- / F 0		M ful la	ra		.)		5	7064		1/7/0	8	
D	(8)		30. Name and address of person who cor	'	eath (Item 2	3a) (Type, I	Print)	1 11	2 (1	/1	/a A		
	(3)		James Chambe	C:-	pr'e Cianatur	[[]	Jet	ヤサ	O- Ste	versur (L	4 40		21661
	Sta		31 Date filed (Month, Day, Year)	32. Registra	a Signatu	mark	,						

			Hegistrar				rimodi	.001	Dealii			Heg. r	VO	N. 100, 100,	
8	Physici /Medic		1. Decedent's Name (First, Middle Burton	e, Last)			LEV	IINE	Ξ		2. Date of D Month JANUA		Day 12	2008	
	Examir		4a. Facility Name (If not institution	n, give street and numb	er)		4b. City	Town, o	r Location	of Death	-	4	4c. Count	y of Death	
			Shady Grove Adv	entist Hos	pital		Roci	kvil	le			1	Mont	gomer	
	Funeral		5. Social Security Number		Age (In yrs.	last birthday		r 1 Year			8. Date of B	Birth		9. Birth	
	Director		096-28-1335	1 X M 2□F	70	Yrs.	Months	Days	Hours	Min.	Jan. 3	3, 1	938	New	
	70	2	Usual Residence of Decedent												
	the Marylan 28a-f show notified at		10a. State 10b. County		10c. Ci	ty, Town or L	ocation							1	
	Mar fled	ţċ	MD Montgo	mery	Pot	omac									
	7 28%	řě	10e. Street and Number				10f. Zij	p Code				10g. (Citizen of	What Coul	
	3a o	2	10602 Farmbrook	e Lane			208	354				U.S	. A .		
	ms 2	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U	I.S. 13	Was Dece	edent of H	lispanic Or	rigin? (Sp	ecify Yes or N Rican, etc.)			ce - Americ	
10	r ite	표	1 □ Never Married 2 📉 Mar		□No Na	vv					Rican, etc.)			ack, White,	
33	urs a al', o Exan	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	s: Kore	an	1 ☐ Yes	2 <u>K</u> i No	Specify	:			Speci	ity: Whi	
ŏ	2 hou	ed	15. Deceden	t's Education		16a. Dec	dent's Usu	al Occup	ation			16b.	Kind of E	Business/In	
7	in 7	ple		st grade completed)	or 5.1)	life.	kind of wo DO NOT u	ork done ise retired	during mo: d)	st of work	ring				
212	The state of the s							inee	r			Fe	dera	1 Gov	
D									18. Moth	er's Name	e (First, Middi	le, Maid	en Surna	me)	
an	d be ental ked c	To B	William Levine					Sady	ye Ka	ıtz					
2	mari mari	F	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mail	ina Addres	s (Street			al Route Num	her Cit	v or Towr	State Zir	
<u>a</u>	d 2 s thar thar 7 is trau		Susan Levine -			1	•	,					,	, , , - ,	
ָט	1 an Heal em 2		20a. Method of Disposition		20b. I	Diana of Dian	iti /A/-				Dete	1 00		- City or To	
ŏ	nt of int		1 XBurial 2 ☐ Cremation		ate Ga	cemetery, cre	en of Remembrance 01/15/2008 Cla								
ţi	t. Pertant		4 □ Donation 5 □ Other (S			Gemet	ery		- :]		0	
Bal	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai		21. Signature of Funeral Service	Licensee		Ē	dward	ng Addre Sag	el Fu	inera	l Dire	cti	on, I	Inc.	
	<u> </u>												ille	, MD	
8			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau only one cause on eac	sed the deat h line.	th. Do not er	iter the mo	de of dyir	ng, such as	s cardiac	or respiratory	arrest,			
	Physician	86	Immediate Cause (Final disease or condition	META	STAT	1C 2	UNG	+ Ci	ANCE	e				i i	
1.	/Medical		resulting in death)		as a consec										
ī.	Examiner	Examiner	Sequentially list conditions	b											
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consec	uence of):									
	ith certificate be executed tending physician and rr use as the burial-transit		that initiated events	С											
ó	exe an ar rial-tı		resulting in death) Last	Due to (or	as a consec	uence of):									
Box 68760,	te be ysicia e bu	an/Medical		d											
68	tifica g ph as th	edi		720						_					
ŏ	ndin use	n/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me pf pregn	ancy							23d. D	ate of deliv	
	death atte	icia	in the past 12 months? 1 □ Yes 2 □ No	1 □ Live birt 4 □ Pregnar	n 2∐Feta nt at time of o	al death 3 death 5	⊒Ectopic p ⊒ Other (s	pecify) _	<i>y</i>				M	lonth	
P.0.	e law requires that the death has been signed by the atte e 2 should be detached for	Physicia	9 ☐ Unknown	9□Unknow	n										
σ.	that ned b deta	P	Part II. Other significant condition	ons contributing to deat	th but not res	ulting in the	ınderlying	cause giv	en in Part	1.	23e. Did	i tobacc	o use cor	ntribute to t	
sp	uires sign ld be	d by									1] Yes	2 🗍 No	3 ☐ Prot	
Ö	v req beer shou	Completed									04= 18/=		0.415	10/	
že	e lav has je 2 t	ldπ							<u>-</u>		24a. Wa	is an lopsy rformed?		. Were auto	
=	: Th cate , pag	S	···-								1□ Yes			death? 1 ∐ Yes	
/its	clan ertifi ector	Be	25. Was case referred to medica examiner?							e of Deat	h (Check only	one)			
Ž	Attending Physician: The law requires that the dea rdeath. ector: Atter this certificate has been signed by the att by the funeral director, page 2 should be detached to	ပ	1 Yes 2 No	Hospital: 1 Inp		ER/Outpatie			4 LI N	ursing Ho	me 5 🗆 Re	sidence	6 □01	her (Specia	
U	ng P tter t nera	Ë	27. Manner of Death 1 X Natural 5 ☐ Pendin	28a. Date of (Month,	Injury <i>Day Year)</i>	28b. Time Injury	of .	28c. Injur Wor	y at k?		28d. Describe	e how in	jury occu	rred	
0	endi	atic	2 Accident investi	gation			М	1 🗍	Yes 2] No					
Division or Vital Records,	er de recte	ti li	3 Suicide 6 Could 4 Homicide determ	inod Zoe. Flace of	injury - At h	ome, farm, s	reet, factor	y, office			28f. Location City or To	(Street	and Num	ber or Rura	
	talo saft alDi	Certification:													
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate hat completely filled in by the funeral director, page		29a. Certifier 1 Certifyir (Check only 2 Medical	ng Physician: To the be Examiner: On the bas	est of my kno	owledge, de	th occurred	at the ti	me, date a	nd place,	and due to th	e cause	(s) and n	nanner as s	
	he H in 24 he F plete	Medical	one)	and mappe	r stated.	along and of	- Julyano	, my C	ווטוווקל, מפ	au occur	red at the time	, uate a	ariu piace	, and ude t	
	With With E	Ž	29b. Signature and title of certifie		/ 1.	///	1 -		e number			29d. [Date sign	ed (Month,	
	1			1	W	V		D 3:	368	6		JA	NUAK	24 12	
	12		30. Name and address of person	who completed cause	of death (Iter	n 23a) (Type	Print)								
			KENNETH D. N	ILLER MD	181	11 PR	INCE	Pi+	ILIA	DR.	OLI	NEY	,	MD	

b. Kind of Business/Industry ederal Government iden Surname) ity or Town, State, Zip Code) MD 20854 c. Location - City or Town, State Clarksburg, MD ion, Inc. 20852 Approximate Interval Between Onset and Death ONE YEAR 23d. Date of delivery Month Year Day co use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No d? ₫No e 6 □Other (Specify) injury occurred et and Number or Rural Route Number, State) se(s) and manner as stated.
e and place, and due to the cause(s) Date signed (Month, Day, Year) NUARY 12 2008 20832 18111 PRINCE PHILIP DR. OLNEY

02529

1145 AM

9. Birthplace (State or Foreign Country) New York

10d. Inside City Limits 1X Yes 2 □ No

4c. County of Death Montgomery

Citizen of What Country?

14. Race - American Indian, Black, White, etc. Specify: White

State

Registrar

31. Date filed (Month, Day, Year)

JAN 15 2008

1 State

32 Registrar's Signature

	for State			iaic o	n iviai yiai		epartment			nd Me	ental Hy			00	0.0	7 0
1. Decedent's Name (First, Middle, Last) 2. Date of Death												Reg. No.	40	08	3. Time	Of Doot!
ian	The decident of the training () most of made of made of											Year				
cal	4a. Facility Name					LIDSK	4b. City, To	own, or Lo	ocation of		JAN.		County of		5:01	P
ner			30												EORGE '	c
	5. Social Security	EL REGI Number	6. Sex		7. Age (In yrs	s. last birtho	day) If Under 1		f Under 2		B. Date of Bi	rth	KINC	9. Birth	place (State	
7	087-18-	7897	1 □ M	2 X F	85	Yrs	s. Months	Days	Hours	Min.	(Month, Di		922	NEV	YORK	
	Usual Residence of	of Decedent			10c C	ity, Town o	r Location								10d. Inside	City Lin
'n					100.0	nty, TOWITO									1 [1] Ye	
Director	MD. 10e. Street and No	MONTGO	MERY				SILVEI		RING			10g. Citiz	zen of W	hat Cou		
				-	A.T	0.5	101. Zip C		.,			rog. Oiliz			, i.i.y .	
Funeral	3158 GRACEFIELD RD. APT 11. Marital Status 12. Was Decedent 8						13. Was Decede	2090 ent of Hisp		in? (Spec	ify Yes or No	U.S.A. or No- 14. Race - American Indian,				
Fun		rried 2 X Marr	ried	Armed Fo 1 ☐ Yes	orces? 2 X No		If Yes, specif	ly Cuban,	Mexican,	Puèrto R	ican, etc.)		Black	, White,	etc.	
by	3 ☐ Widowed	4 Divorced		If Yes, Gi Year or D	ive Dates:		1 ☐ Yes 2	LI No	Specify:				Specify:	WE	HITE	
ted	(Sne	15. Deceden	it's Education	on omnleted)			ecedent's Usual Give kind of work			of working	7	16b. Kir	nd of Bu	siness/In	dustry	
ompleted	Elementary/Sec	ondary (0-12)		College (1-4or 5+)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	fe. DO NOT use	retired)	_		,					
O	17 Fotborio Name		Lost)				HOMEN			's Norse	Eirot Midde	HOME a, Maiden Surname)				
Be	17. Father's Name				OD A TOTAL	D.		11	o. womer							
은	19a. Informant's N	MAURIC Name/Belations		Print)	SPAISE		failing Address (Street and	d Number		LORA Boute Numl		KATZ		n Cade)	
		LIDSKY/		,			8 GRACEI					-				209
	20a. Method of Dis		позде	МЪ	20b.	Place of D	isposition (Name	e of	, кр.	AF I					own, State	ъ.
		Cremation		oval from	I .	-	crematory or oth		1	16	2000	DTIT	TIDD A	T 177	MD	
10a. State 10b. County 10c. City, Town or Location 10d. City 10d. Zip Code 10d. Zi																
21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P 5801 CLEVELAND AVE., RIVERDALE, MD. 20													O737			
	Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. HYPERTENSION Due to (or as a consequence of):													1	Onset and	etween d Death
cal Examiner	disease or condition resulting in death Sequentially list of fany, leading to cause. Enter Uncouse (Disease of that initiated even	onditions, immediate derlying or injury ts	∫ b. <u>M</u>	Due to YOCA Due to YPER	(or as a conse IRDIAL (or as a conse ITENSIO)	INFAR equence of)	CTION	3								
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by Physician/Medical Examin	disease or condition resulting in death resulting in death set of any, leading to cause. Enter Unc Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was deceded in the past 1 1 1 res 2 9 unknow Part II. Other sign	onditions, mmediate lerlying or injury its Last nt pregnant 2 months? XI No n	b. M. c. H. d 23c.	Due to YPER Due to If yes, out 1 Live 4 Pregi 9 Unknowning to d	(or as a conse	rquence of): INFAR(equence of): N rquence of): nancy tal death	CTION : : 3 □Ectopic pre 5 □ Other (spe	cify)	în Part I.		1 🗆	tobacco u Yes 2[Mor	ibute to t	onset and	Year f death?
pleted by Physician/Medical Examin	disease or condition resulting in death resulting in death series of any, leading to cause. Enter Unc Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1 1 yes 2 9 Unknow Part II. Other sign PULM OSTE	onditions, mmediate lerlying or injury ts Last Int pregnant 2 months? X No no inflicant condition on the condition of the condition on the condition of the condition on the condition on the condition of the condition on the condition of the c	b. P. c. H d 23c. PIBROS	Due to YOCA Due to YPER Due to If yes, ou 1 Live 4 Pregi 9 Unkn Duting to d	(or as a conse	rquence of): INFAR(equence of): N rquence of): nancy tal death	CTION : : 3 □Ectopic pre 5 □ Other (spe	cify)	in Part I.		1	tobacco u Yes 2[s an opsy ormed?	Moruse contri	ibute to 1 3 Pro Vere auto	onset and	Year f death
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08-00698	
Gregory Moore	

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State of Maryland / Department of Health and Mental Hygiene 2008 02531

	1- For State Registrar Certificate of Death Reg. No.											
Physician/												
Medical Examine	87							January .	25, 2008	0635 118		
	4a. Facility Name (if not institution 8632 Cobblefield Driver		nber)		4b. City, Town Columbia		ition of De	eath	4c. County of Howard	.f Death		
Funeral	5. Social Security Number	6. Sex 7	7. Age (In yrs. la	ast birthday)	If Under 1		Under 24		Birth (MM/DD/YYYY) 9. Birthplace (State or			
Director	255-31-9222	1 X M 2 F	30	Yrs		Days F	Hours 1	Min. 11/0	/01/1977 Foreign Country Georgia			
7	Usual Residence of Decedent	A						1 , -				
v any	10a. State 10b. County		10c. City,	Town or Locat	ion					10d. Inside City Limits		
Maryland 28a-f show 1 at once. ector	Maryland Howar	rd		Colum	nbia					1 X Yes 2 No		
the Maryland a or 28a-f sh tified at once Director	10e. Street and Number				10f. Zip Cod				10g. Citizen of Wh	•		
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Fur it dear	2 Midowod 4 Diversed III Ves Give Vest 1 Ves 3/N Ne secsión											
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica To Be Comple	Tr. Father's Name (First, Middle, Last) David J. Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town,											
215 be fill mtal H riked ent, t												
D 21 Outld Me is ma tic ev												
MC id 2 sl lith an in 27 i	Jayne E. Moore/ Mother 435 Penwood Drive, Edgewater, MD 2103 20a. Method of Disposition 1 Burial 2 Y Cremation 3 Removal from State 30b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - C											
s l an of Hea												
Page Page nent c ant: or oth	4 Denation 5 Other Sa	1/27/08	Edgew	water, MD								
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	would ulle			2	.973 So	lomo	ns Is	sland Rd	. Edgewat	er, MD 21037		
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
taminer	Immediate Cause (Final disease or condition resulting in death) a. Alcohol and zolpidem intoxication Due to (or as a consequence of):											
		Due to (or as a o	consequence of):								
Je Je	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	consequence of	·):								
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8760, ificate be up physical sthe buri	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, or	atcome of pregr	nancy					23d. Date of			
	past 12 months?	Live bit	th nt at time of dea	ath	etal death ther (Specify)	3E	ctopic pre	gnancy	Month	Day Year		
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s, P.C								_ 1 Y	es 2 √ No 3	Probably 4 Unknown		
ord; w requisions been should								24a. Wa aut	opsy p	Were autopsy findings available prior to completion of cause of		
Records, The law requires ficate has been sig page 2 should be								per 1 ✓ Yes		death? ✓ Yes 2 No		
Vital Recysician: The his certificate director, page	25. Was case referred to medical examiner?				26.P			eck only one)				
f Vit Physic or this cral dire		Hospital: 1 In	patient 2	ER/Outpatient		Othe	² 74 Nu	ursing Home 5	Residence 6	Other: Scene		
ling Pt After t funeral	27. Manner of Death 1 Natural 5 Death		f Injury Day,Year)	28b. Time of		Injury at			e how injury occurre	ed		
ivisior or Attendafter death Director:	2 Accident Inves	stigation 17	25/2008	Fnd 8:3			2 X No					
Division of Vital Records, spital or Attending Physician: The law requirements after death. Ineral Director: After this certificate has been signified in by the funeral director, page 2 should be Certification: To Be Completed	3 Suicide 6 X Could	a not be	of Injury - At ho	me, farm, stre	et, factory, offi	ce buildir	ng, etc.	or Town	State)	er or Rural Route Number, City		
S file bou	29a. Ceruller	rmined (Specify)		an dooth occur	red at the time	dote or	nd place			Or. Columbia, MD		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the I		miner: On the basis of and manner sta	examination ar									
F > F ° ×	29b. Signature and title of certifie				29c. Lic	ense nur	mber		29d. Date signe	ed (Month, Day, Year)		
	Worvine on	e Shell			0	C.M.E			January 26	, 2008		
	30. Name and address of person				onn Ct :	D-20		ID 04004				
	Margarita Korell MD.	Assistant Medi	cal Examin		enn Street	, baitin	nore, IV	ID 2 120 T	 			
State Registrar	31. Date filed (Month, Day, Year) JAN 2	8 2008	See a	K								
DHMH 17 Rev 1/2001				ORIGINA	L			- <u></u>		OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 1902 11 Helen /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Arinde Anne AAMC Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Jul 28, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Min 1 □ M 2 🗓 F 77 1930 213-28-5756 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√2 No MD Anne Arundel Annapolis Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21401 211 Winchester Beach Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status and 2 should be filed within 72 hours after de. 27 Is marken and Mental Hygiene. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White 3altimore, Maryland 21215-0036 Specify. ð 3 ₩ Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Helen Wiencke Raymond Timanus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 shot Health ar Annapolis, MD 21401 211 Winchester Beach Drive Dr. William F. Martin III/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 14, 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If iter any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 3 ☐Removal from State Baltimore, Maryland Metro Crematory 2008 21. Signature of Fune of Service Lice se 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy, P.A. Severna Park Funeral H. Hwy, Severna Park, MD 21146 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician hours Syncopes /Medical Due to or as a consequence of): Examiner inkumi Devers Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician Physician/Medical for use as the IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🔼 No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9 I Inknown 9 Unknown s been signed by the should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has b rector, page 2 s autopsy 2 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the nocytos after death. To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie MO D0061783 2008

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person

31. Date filed fonth, Day,

Choi

Year)

JAN 1 5 2008

, MD

ORIGINAL

21401

who completed cause of death (Item 23a) (Type, Print)

32. gistrar's Signature

2001

Medica

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 Stephen C. January 3:08 P Miller /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F 3, Director 213-42-6557 62 1945 Mar. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits show r 28a-f sh notified 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Riva 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e Items 23a 2813 Cedar Drive 21140 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Iter 1 Never Married 2 Married "natural", or li edical Examin 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesman Auto Sales 17 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Albert Miller, Jr. Ethel Gertrude Byron 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any injury or other trau Anissa M. Hastings/daughter 1903 Gallant Knight Lane Mt. Airy, MD. 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Metropolitan Crematory 1/11/2008 Alexandria, VA. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licers 6512 NW Crain Hwy. Bowie, MD. 20715 Ch 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** acute 10 mmuto /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any scaling Lemmodal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to jor as a consequence of physician and the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of): Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1- Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s perform 2 No Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38563

C 2

Baltimore, Maryland 21215-0036

Box 68760,

Division or Vital Records, P.O.

State Registrar

31. Date filed (Month, Day, Year)
JAN 0 8 2008

Wayne



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RD,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

> Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760

ģ	MD MONTGOMERY	POOL	POOLESVILLE									
irec	10e. Street and Number		10f. Zip Code		10g. 0	Citizen of What Co	untry?					
alD	17813 DOCTOR WALLING F	RD.	2083	7		USA						
ner	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White						
To Be Completed by Funeral Director	1 Never Married 2 Married 1 Yes, 2 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No	Specify:	7.104.17	Specify: WHITE						
eted	15. Decedent's Education (Specify only highest grade completed)	16a. D	ecedent's Usual Occup Give kind of work done	ation	ing 16b.	16b. Kind of Business/Industry						
mpl	Elementary/Secondary (0-12) College (1-4or	5+)	ife. DO NOT use retired CTAIL SALI	1)		LOTHING						
ပ္ပ	17. Father's Name (First, Middle, Last)	1(1)	THIL OAD		e (First, Middle, Maide							
To Be	SIDNEY ARTHUR DUNT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2)											
	19a, Informant's Name/Relationship (Type. Print)	or Town, State, 2	Zip Code)20837									
	KARINA FLYNN / DAUGHTER 17813 DOCTOR WALLING RD., POOLEST 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City of Communication 20c. Location - City of Communication											
	20a. Method of Disposition 1 ☐ Burial 2 Scremation 3 ☐ Removal from State	Location - City or										
	4 Donation 5 Other (Specify) 21. Signature of June Service Decease	STRUFF	ER CREMAT		6/08 F	REDERIC	K, MD					
	21. Signature of Junean Service growthsee		22. Name and Addre HILTON E P.O. BO	UNERAL	HOME RNESVILL	E. MD	20838					
	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	the death. Do not ne.	t enter the mode of dyir	ng, such as cardiac	or respiratory arrest,	122	Approximate Interval Between					
	Immediate Cause (Final disease or condition	roma In	furtion				Onset and Death					
	resulting in death) Due to (or as	a consequence of)	-				1					
-	Sequentially list conditions, b.	a consequence of)	emil	_			un known					
mine	cause. Enter Underlying Cause (Disease or injury	mater was	•				unknown					
Exal	that initiated events resulting in death) Last C. Due to (or as	a consequence of)	:									
cal	d											
Med	IF FEMALE:											
an/I	23b. Was decedent pregnant 23c. If yes, outcome	pf pregnancy 2 Fetal death	3 □Ectopic pregnance		23d. Date of de	livery Day Year						
Completed by Physician/Medical Examiner	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)											
y Pt	Part II. Other significant conditions contributing to death b	ut not resulting in th	ne underlying cause giv	en in Part I.	23e. Did tobacc	use contribute to	the cause of death?					
ed b	Devrention				1 ☐ Yes	20 No 3 □ Pi	robably 4 DUnknown					
plet	Osteouthits				24a. Was an	24b. Were at	utopsy findings available					
mo.	Anemia				autopsy performed? 1 Yes 2 1	 v prior to completion of cause 						
Be (25. Was case referred to medical examiner?				h (Check only one)							
P		ent 2 ER/Outpa	atient 3 DOA Oth	er: 4 Nursing Ho	me 5 Residence	6 □Other (Spe	cify)					
ion:	27. Manner of Death 1 Natural 5 Pending (Month, Daily County) 1 (Month, Daily County)		ury 286. Injul	y at	28d. Describe how in	be how injury occurred						
icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of in	iury - At home, farm	n, street, factory, office	_	28f. Location (Street	and Number or R	ural Route Number					
Certif		tc. (Specify)	.,,, ,		City or Town, Sta	ate)	ara riouto rumbor,					
Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and/	death occurred at the ti or investigation, in my	me, date and place, ppinion, death occur	and due to the cause red at the time, date a	(s) and manner as	s stated. e to the cause(s)					
Me	29b. Signature and title of certifier	- 1 0	29c. Licens	e number	29d. f	Date signed (Moni	th, Day, Year)					
	> mun V. by / m	ranily Muys	ilian H61	505	/	117/08						
	30. Name and address of person who completed cause of c	leath (Item 23a) (T)	ype, Print) Shor Ave, St	J Poolesi	lle MD 208	37						

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 8 2008

O. Box 68760,)	Baltimore, Maryland 21215-0036
ne death certificate be executed	Phy /W Exa	permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary
the attending physician and	/sid led ami	Department of freath and mental rightens. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f sho
hed for use as the burial-transit	cia ica ine	any Injury or other traumatic event, the Medical Examiner must be notified a

			For State	State of Mar	•	partment of F ertificate of			giene Reg. No.2 () (08 02535		
			Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Dea	eath 3. Time of Death			
	Physici		Leonard Arthur	McCaffe	rtv			JAN. 11	, ^{Day} 2008	1:35 P. M		
	/Medio	1650	4a. Facility Name (If not institution, give		or cy	4b. City, Town, o	or Location of Death	4c. County				
7	EXAMILI	eı	Suburban Hospital			Bethesd	la		Montg	Montgomery		
	Funeral		5. Social Security Number 6. Se	y) if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl	h Year)	9. Birthplace (State or Foreign				
	Director		016-24-4217	XM 2□F	Widnitis Days	Hours Will.	NOV. 8	, 1931	Massachusetts			
	pu ,	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits		
	arylar show d at	_	,		,					1 Yes 2 No		
	8a-f	Director	Maryland Montgome	ry	Rockvil	1		Ţ.	10g. Citizen of V			
	with the		10e. Street and Number			10f. Zip Code			_	_		
	s 23g	era	1749 Crestview Dr		orin II S 1	20854	Hienanic Origin? (St		United 14 Baco	States e - American Indian,		
	item item	1749 Crestview Drive 1. Marital Status Status								k, White, etc.		
36	Irs af								Specify	White		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Completed	15. Decedent's Edu	cation	16a. De	cedent's Usual Occu	pation	Line -	16b. Kind of Bu	usiness/Industry		
215	e. an "n Med	ed l	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	'iii	e. DO NOT use retire	d)	K#Ig				
	filed wit Hygien sther the	lo lo	12			cturing						
nd	be filed within 72 hours after death with the Marylan ital Hygliene. d other than "natural", or items 23a or 28a-f show other, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	Maiden Surnam	ıe)							
Уlа		ပ္	Francis A. McCaff	mpson								
Maryland	s 1 and 2 should of Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (T)	State, Zip Code)								
	1 and 2 Health tem 27 I		Joyce A. Gorman - s 20a. Method of Disposition	sister		9 Crestvie sposition (Name of crematory or other pla				City or Town, State		
יסר	nt of it		1 ☐ Burial 2 🛣 Cremation 3 🗆 l		Riverda	rematory or other pla 1e Park	, OTHER					
Baltimore,	ift. Partme		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens		Cremato	rv	2008			le Park, MD		
Solution Committee Commi										o. MD 20910		
	-		23a. Part1. Enter the disease, or comp	lications that caused th	ne death. Do not					Approximate Interval Between		
	Physician		shock, or heart failure. List only of Immediate Cause (Final			N FAILURE				Onset and Death		
	/Medical	Ш	disease or condition resulting in death)		consequence of):	N LYTHOKE						
١.	Examiner		Sequentially list conditions	SEPTIC S	носк							
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	consequence of):							
	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. PNEUMONI	A consequence of):							
8760,	be ex cian burial	E		Due to (or as a	consequence or,							
87	physicate the last	Physician/Medical	•	d								
9 X	leath certific attending p	Me	IF FEMALE:	23c. If yes, outcome pt	pregnancy				23d Da	te of delivery		
Вох	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti		3 Ectopic pregnand 5 Other (specify)	cy			onth Day Year		
P.0.	w requires that the d been signed by the should be detached	iysi	1 Yes 2 No 9 Unknown	9□Unknown								
	s that hed b		Part II. Other significant conditions co	ontributing to death but	not resulting in th	e underlying cause gi	ven in Part I.	23e. Did to	obacco use cont	tribute to the cause of death?		
Records,	quire; n sig uld be	Completed by	RENAL FAILURE					101	Yes 2X No	3 ☐ Probably 4 ☐ Unknown		
တ္တ	s bee	Set						24a. Was		Were autopsy findings available		
Ä	The lay te has age 2	mo						autop perfo 1□ Yes	rmed?	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No		
Vital		Be C	25. Was case referred to medical				26. Place of Dea	ath (Check only o	21			
>	Physic this ce al direc	To E	examiner? 1 □ Yes 2 X No	Hospital: 1 🔀 Inpatient	t 2 ☐ ER/Outpa	tient 3 DOA Ot	her: 4 Nursing H	lome 5 Resid	dence 6 □Oth	ner (Specify)		
0	dIng Phy h. After thi funeral o		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tim		ury et ork?	28d. Describe	how injury occur	red		
Sio	endli eath. or: A	atic	2 ☐ Accident investigation				Yes 2 No					
Division or	or Att ter de lirect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	y - At home, farm (Specify)	street, factory, office		28f. Location (S City or Tov		per or Rural Route Number,		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 X Certifying Phy	ysician: To the best of	my knowledge o	eath occurred at the	time date and place	and due to the	rause(e) and m	anner as stated		
	Hos 24 ho Fun etely	Medical			examination and/o					and due to the cause(s)		
	omple	Me	29b. Signature and little of certifier		_	29c. Licen	se number		29d. Date signe	(Month, Day, Year)		
	7-6		4111			700	06302		1/14	100		
	16		30. Name and address of person who o	completed cause of dea	ath (Item 23a) (Ty		001/50					
			Atul Rohatgi, M.D			town Road	, Bethesd	a, MD 20	0814	V		
	Sta	ate	31. Date filed (Month, Day, Year)	32 egistrar	's Signature	1.5						

			For State Registrar		State of	Marylan		artment o <i>rtificate (</i>		ealth and N Death	Ment	_	jiene leg. No./	2008	025	36	
	p 2	i i	Decedent's Name	(First, Middle, La					ate of Dea	th		3. Time of I					
	Physicia		Alfred	Harold 1	Moss						,	_{lonth} nuarv	Day 10.	Year 200 8	8:15	рм	
٧	/Medic Examin		4a. Facility Name (If	not institution, giv	e street and numb	per)		4b. City, Tow	vn, or	Location of Death	1		4c. C)			
	Funeral Director		5. Social Security No			. Age (In yrs. I	last birthday) Yrs.	Yrs. Months Days Hours Min. (Month,						Birth Day, Year) 9. Birthplace (State or Foreign Country) 9. Virginia			
ì			578-18-1 Usual Residence of			91					יוחד;	у ь,	1916	Virg			
	ylan how at		10a. State	10b. County		10c. City	y, Town or Lo	ocation							10d. Inside Cit		
	a-f s	Director	Maryland		Montgom	ery		Silver	Sp	ring					1 🗆 Yes	Z K No	
	or 28	ä	10e. Street and Nun	nber				10f. Zip Co	de			1	10g. Citiz	en of What Cou	untry?		
	23a ust b		1713 B1	ack Oak	Lane				209					USA			
36	filed within 72 hours after death with the Maryland Hygiene. Hyer than "natural", or Items 23a or 28a-f show ort, the Medical Examiner must be notified at	by Funeral	11. Marital Status1 □ Never Marri3 □ Widowed	ied 2 Married	12. Was Deced Armed Ford 1 Types 2 If Yes, Give	lent Ever in U. :es? 2 □ No es: 1940•	S. 13.	Was Decedent If Yes, specify 1 ☐ Yes 2 ☐		spanic Origin? (S n, Mexican, Puert Specify:	pecity Y to Rican	es or No- i, etc.)		4. Race - Amer Black, White Specify: Wh			
5-0036	hour tural		3 🔲 Wildowed	15. Decedent's E		es. 1340	16a Dece	dent's Usual O	ccupa	ntion		-1	16b. Kin	d of Business/la	ndustry		
ပုံ	n 72 i "na"	Completed		cify only highest gr	ade completed)		i (Give	kind of work a DO NOT use re	lone d	urina most of wor	rking	- 1		ed Stat			
71.	withi iene. thar the M	E O	Elementary/Seco	ndary (0-12)	College (1~	4or 5+)		Militar	~v (Officer				d Force			
O	d be filed ental Hyg ced other c event, 1	Be C	17. Father's Name ((First, Middle, Las			1	11111111111111		18. Mother's Nan	ne (Firs						
Maryland	ld be lental ked o ic eve	To B	Alfred	Lee Mos	s					Bena	Lak	es					
2	should ind Men marke	_	19a. Informant's Na	ame/Relationship	Type. Print)		19b. Maili	ing Address (St	treet a	and Number or Ru	ural Rou	ıte Numbe	r, City or	Town, State, Z	ip Code)		
Š	and 2 ealth a n 27 Is er trau		Ruth U.	Moss/Wif	e		1713	Black (ak	Lane, S	ilv	er Sp	ring	, MD 20	901		
altımore,	of H			☐Cremation 3 ☐		late		osition (Name of		, ~ ~ ~ .	Date 2	7,		cation - City or T			
	permit. Page Department of Important: If any Injury or once.		4 ☐ Donation 21. Signature of Fu	5 ☐ Other (Speci		Ari:	Cemete	Nation Name and A	ddres		000		Arli	ngton,	Virgin	ia	
ñ	Depart Impo				2-0			Francis	J	. Collin							
	¥ 3		23a. Part1. Enter ti	he disease, or con	plications that ca	used the deatl	h. Do not er	500 - Uniter the mode o	t dying	rsity Bl	. vd , c or res	piratory ar	Silv rest,	er Spr	poroximate	3000	
	Db	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Cardiac Arrest												1	Interval Bet Onset and I	ween Death	
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Box	death certific e attending p d for use as f	Physician/M	IF FEMALE: 23b. Was deceden	it pregnant	23c. If yes, outc								2	3d. Date of deli	ivery		
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ري ت	res that the de signed by the a be detached t	by PI	Part II. Other signi	ficant conditions	contributing to dea	ath but not res	ulting in the	underlying caus	se give	en in Part I.		23e. Did to	obacco u	se contribute to	the cause of d	leath?	
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000	w require s been sis	lete										24a. Was		24b. Were au	itopsy findings	available	
Re	: The law cate has I	Completed											rmed?	death?	completion of c	ause of	
Vita	un: T		25. Was case refer	rred to medical	1					26. Place of Dea		1□ Yes eck only o		1 □ Yes	2 □ No		
>	/slcian; s certific lirector,	o Be	examiner? 1 ☐ Yes 2 ☐		Hospital: 1 □ Ir	patient 2-	ER/Outpatie	ent 3 DOA	Othe	DF:				Other (Spe	cify)		
ō	y Physer this eral di	-	27. Manner of Deat		28a. Date o	f Injury	28b. Time		. Injury Work		1	Describe h			ony)		
0	nding P th. : After t funera	tior	1 🙀 Natural 2 🔲 Accident	5 ☐ Pending investigation	1 '	n, Day Year)	Injury	М		<br Yes 2 □ No							
Division or	I or Attend after death Director:	fica	3 ☐ Suicide	6 Could not be determined	28e. Place	of injury - At h	ome, farm, s	treet, factory, o	ffice		28f. L	ocation (S	Street and	d Number or Ru	ural Route Num	nber,	
	al or after Dire	Certification:	4 ☐ Homicide		Dullain	ig, etc. (Specii	ry)				1	City or Tov	vn, State,	,			
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier (Check only		hysician: To the miner: On the ba											3)	
	the Ihin 24 the Inthe Interession and In	Medical	one)		and mann												
	To To	2	29b. Signature and		0 1/1.	,	110	29c. L		62432			29d. Dat	e signed <i>(Mont</i> Januar	h, Day, Year) ry 10,	2000	
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	10,		30. Name and add	V						a : -				00010			
				. Meers,					oad	, Silver	Sp	rıng,	MD	20910			
	Sta Registi		31. Date filed (Mor		108	egistrar's Signa	K A	antie									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Randall James Mariner 6520AM 16 08 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Coastal Hospice Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/16/1927 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 X M 2 □ F 220-26-8480 80 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2/☐ No Director MD Snow Hill Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 105 N. Church St. 21863 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛛 No Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Worcester County Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Otho M. Mariner, Sr. Ella Gray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 N. Church St., Snow Hill, MD 21863 Joanne B. Mariner / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Bates Cemetery 1/19/2008 Snow Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part1. Entor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHOLANGIOCARCINOMA disease or condition resulting in death) Due to (or as a consequence of): CARCINOMA METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ♣️No 24a. Was an autopsy performed 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Fripatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Examiner law requires that the death certificate be executed use as the burial-trar P.O. Box 68760, signed by the a d be detached for or Vital Records, page 2 s certificate this or Attending

the funeral After within 24 hours after death To the Funeral Director: completely filled in by

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notifled at

artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natur Injury or other traumatic event, the Medical I

Physician

/Medical

2 should be finance and Mental H

filed within 72 hours after death with the Maryland

21215-0036

Maryland

altimore,

Pages

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6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

29b. Signature and ittle of certifier

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as states.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) D0058410

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

P. v Box 1733 Strisgung uno 21802 WHALE COASTAL HOSPICA 6 Hustu

State Registrar

BA 10+1

31. Date filed (Month, Day, Year) JAN 1

Physician /Medica Examine

	for State Registrar	State of Mary		irtment o <i>tificate d</i>				giene? Reg. No.	008	02538
	1. Decedent's Name (First, Middle, Last) Clifton Ev	verett	01sen				2. Date of Dea Month	Day	Year	3. Time of Death
	4a. Facility Name (If not institution, give si	treet and number)	-	4b. City, Tow	n, or Location	of Death	January	4c. Co	2008 ounty of Death	
	St. Catherines Nu	rsing Cente	r	Emmits					Frederi	
	5. Social Security Number 6. Sex 220–18–2025	7. Age (In 82	yrs. last birthday) Yrs.	If Under 1 Yo Months Da		r 24 Hrs. Min.	8. Date of Birt (Month, Da)	y, Year)		place (State or Foreign ntry)
	Usual Residence of Decedent	02	113.				May 4,	1925	Mary	land
	10a. State 10b. County	100	c. City, Town or Lo	cation						10d. Inside City Limits
	Maryland Frederick 10e. Street and Number		Thurmont	101 7:- 0				10- 03:		1 ☐ Yes 2 No
	14838 Old Camp Airy	v Road		10f. Zip Cod	.788			_	in of What Cou USA	ntry /
5		2. Was Decedent Ever	in U.S. 13. \	Was Decedent	of Hispanic O	rigin? (Spe	ecify Yes or No	. 14	Race - Amen	
3	1 Never Married 2 Married	Armed Forces? 1⊕Yes 2□No 1#Yes, Give		f Yes, specify (Hican, etc.)		Black, White,	
2	3 ☐ Widowed 4 🛣 ivorced	Year or Dates:	WII	Yes 2√2	ac Specily	· .		3)	pecify: W	Thite
	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Oo kind of work do DO NOT use re	cupation one during mo	st of worki	ing	16b. Kind	of Business/In	ndustry
1	Elementary/Secondary (0-12)	College (1-4or 5+)		enance				Camp	Ground	ls
9	17. Father's Name (First, Middle, Last)		01				(First, Middle,	Maiden Su		
2	Walter		01sen			la			Eyler	
	19a. Informant's Name/Relationship (Typ	oe, Print)		-			Al Route Numbe			
	Tim Olsen (Nephew) 20a. Method of Disposition	20	1483 Ob. Place of Dispo				y Koad,		mont, M	D 21788
	1 XBurial 2 ☐ Cremation 3 ☐ Re		ob. Place of Dispo- cemetery, crem ethel Ge		Cem		/2008		ade, MI	
	4 □Donation 5 □ Other (Specify) 21. Signature of nuneral Service License			. Name and Ad	<u> </u>					
	+ Hocer W.L.	2000					Stauffer , Thurm			
	23a. Part Brief the disease, or complice sheck, or seart failure. List only on	cations that caused the								Approximate Interval Between
	Immediate Cause (Final disease or condition	Sudat	200 R		u) or					Onset and Death
	resulting in death)	Due to (or as a cor	nsequence of):	41			Pose	OT		
	Sequentially list conditions, b.									
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	isequence or):							
	that initiated events c. resulting in death) Last	Due to (or as a cor	nsequence of):							
5	0.									
	23b. Was decedent pregnant	Bc. If yes, outcome of pr		Ectopic pregna	MOCV			230	d. Date of deliv	•
	in the past 12 months? 1 □ Yes 2 □ No	4 □ Pregnant at time 9 □ Unknown		Other (specify					Month	Day Year
	9 ☐ Unknown Rart II. Other significant conditions cont		A	4.4.5	- in Don		22a Dida	}		the cause of death?
	Doggana Ti Co	modified to dealif but no	t resulting in the dr	idenying cause	given an Fan	1.	1 🗆 ነ			
	psingre	1. 1	1) 0 =							
	Coronary,	HAJUT	1) 00	all.				rmęd?	prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available ompletion of cause of
	25. Was case referred to medical				26. Plac	e of Death	1 ☐ Yes	2/2 No	1 🗆 105	20 140
	examiner?	ospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA	0.1		me 5 Resid		☐Other (Speci	fy)
	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury		njury at Work?	-	28d. Describe h			
	2 Accident investigation 3 Suicide 6 Could not be				I∐Yes 2□		-8			
	4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, stro oecify)	eet, factory, off	ce		28f. Location (5 City or Tox	Street and I vn, State)	Number or Run	al Route Number,
	29a. Certifier 1 Cartifying Physi	ician: To the best of my	knowledge, death	occurred at th	e time, date a	nd place, a	and due to the	cause(s) ar	nd manner as s	stated.
	(Check only 2 Madical Examin one)	ar: On the basis of examined manner stated.	mination and/or inv	estigation, in r	y opinion, de	ath occurr	ed at the time,	date and pl	lace, and due t	to the cause(s)
	29b. Signature and title of certifier			29c. Lic	ense number	144	EN SI	29d. Date :	signed (Month,	Day, Year)
	Don Tal x	Rouge	e- Rig	TRUTO	3	TI	-1/	>1 -	16-	2008
				1	10 1		20)	4 4 .	0	

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year) 1 8 2008

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State of Maryland / Department of Health and Mental Hygiene 2008

			State of Maryland / Department of	Health and M	lental Hygie	ne 2 0 0 8	02539
			1- State Registrar Certificate o	f Death		. No.	0 4 0 0 5
	F	-	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
3	Physicia		Nancy Clagett O'Neill		Month January	13, 2008	6:45p M
	/Medic Examin		, oragere	, or Location of Death		4c. County of Death	-
			Morningside House of Friendship	Hanover		Anne Arun	del_
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Yes Yrs. Months Day		8. Date of Birth (Month, Day, Y	ear) 9. Birthp	lace (State or Foreign stry)
	Director		220-28-6736 73 Usual Residence of Decedent		Feb. 13	, 1934 Mar	yland
	land ow		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	Mary -f shi	tor	Maryland Anne Arundel Hanover				1 ☐ Yes 2☐No
	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notifled at	Director	Maryland Anne Arundel Hanover 10f. Zip Code	e	10g	. Citizen of What Cour	itry?
	th wit 23a c 1st be		7548 Old Telegraph Road 21076			USA	
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of If Yes, specify Control of Yes	f Hispanic Origin? (Sp uban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	s afte	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No			Specify:White	
Maryland 21215-0036	hour tural	q pé		cupation	16	b. Kind of Business/Ind	duetry
5	within 72 ene. than "na he Medic	Completed	(Specify only highest grade completed) (Give kind of work dor	ne during most of work ired)	ing	b. Tana of Basilless/III	lustry
212	yiene giene r thai	lmo	Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker			Orm Hama	
ğ	other vent, tl	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	Own Home iden Surname)	
<u>Ja</u>	uld be Mental irked c	To E	Joseph Donald Clagett	Helen H	Barron		
ar J	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. It Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Stre	et and Number or Rur	al Route Number, C	City or Town, State, Zip	Code)
_	s 1 and 2 of Health a Item 27 is other tra					, Maryland	
0	t of H If Itel		20a. Method of Disposition X⊠ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other processing to the complex of t			c. Location - City or To	wn, State
	t. Partmen tant:		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	~ · · · · · · · · · · · · · · · · · · ·	17, 108 Si	lver Sprin	g, Maryland
Baltimore,	permit. Pages 1 a Department of He Important: If Item any Injury or othe	0	Francis	J. Collins	Funeral 1	Home Inc.	
	441		23a Part I Enter the disease or complications that raised the death. Do not enter the mode of	ersity Blvo	N. Si	lver Spring	MD 20901 Approximate
		i la	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of c shock, or healt failure. List only one cause on each line. Immediate Cause (Final	lying, such as cardiac	7	1-	Interval Retween
)	Physician / /Medical		disease or condition resulting in death)	The pu	monari	VISECUSE	gears
	Examiner		Due to (or as a consequence of):				0
		ler	Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	outed id ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events C.				
Ď,	be executed ician and burial-transit		resulting in death) Last Due to (or as a consequence of):				
3/60	0 0 0	lical	d				
× 60	certificat nding phy use as the	Physician/Med	IF FEMALE:			1	
X P P	ath cuttend	ian/	23b. Was decedent pregnant in the past 12 moorns?			23d. Date of delive Month	ery Day Year
o.	the death y the atter iched for u	ysic	1 Yes 2				
7.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did toba	use contribute to the	ne cause of death?
Hecords,	uires 1 sign 1d be	d by			1 D Yes	2 No 3 Prob	pably 4 Unknown
ဂ ္ဂ	The law requires that te has been signed boage 2 should be deta	Completed			24a. Was an	24b. Were auto	psy findings available
Ž Ž	The la e has age 2	dmc			autopsy performe 1∐ Yes 2		mpletion of cause of
VII		Ф	25. Was case referred to medical	26. Place of Deat	1 Yes 2 III Yes 2 IIII h (Check only one)	Z No 1 □ Yes	Assisted
	Physician: r this certific ral director,	O B	examiner? 1 Yes 2 No	Othor:		ce 6 Dother (Specif	y Living
סר	iding Phys h. After this funeral dir	T:U	27. Manner of Death 1 Matural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Ir Natural 1 Matural 1 Matural 2 Matural 2 Matural 2 Matural 3 Matura		28d. Describe how		
IVISION	Attending r death. ector: After by the fune	atio	2 Accident investigation M 1	☐Yes 2☐No			
Ĕ	or Att ter de lirect	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	ce	28f. Location (Stree City or Town,	et and Number or Rura State)	ıl Route Number,
	urs af	Ce					
	he Hospital or Attendi n 24 hours after death. he Funeral Director: A pletely filled in by the f	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the check of the check o	e time, date and place, ny opinion, death occui	and due to the cau rred at the time, dat	ise(s) and manner as s e and place, and due to	tated. the cause(s)
	To the Ho within 24 I To the Fu completely	Med	, and marries states	ense number	290	I. Date signed (Month,	Day, Year)
1	r ≤ F ő		I X A A MD D	50725	5 1	-14-	2000
7	9		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	. ,	111	1/	
			denn for Kiedinger 8601 Vatoran	SHINII	Villor	sville !	ND 3/168
	Sta		31. Date filed (Month, Day, Year)	1			
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Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Olson 10:25p January 10, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Silver Spring 1001 Lanark Way Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🕱 F Vrs 26, 96 1911 Michigan 577-14-3352 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count 28a-f ehow rthen "naturel", or items 23a or 28a-f ehov the Madical Examiner must be notified at 1 Yes 2 X No Maryland Silver Spring Montgomery Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1001 Lanark Way USA 20901 death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: þ 3 € Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other eny liqury or other traumatic event, page. 17. Father's Name (First, Middle, Last) Emanuel Krans Johnson Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald W. Olson/Son 1001 Lanark Way, Silver Spring, MD 20901 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) ★ Burial 2 Cremation 3 Removal from State 15, Jan. Parklawn Memorial Park 4 □ Donation 5 □ Other (Specify) 2008 Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Lucio 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Advanced Alzheimer's Diseaso Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 \(\text{No.} 23C No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) ို 1 ☐ Yes 2€ No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After s after deau.
ral Director: Aftr 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide filled within 24 hours a To the Funeral C completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ujwamaditya. D. Redy ND D 43464 JANUARY-14-2009 ROLKUIUS PILE, SUITE WE, ROLKVILLE, MD-20852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIKRAMADITYA D REDDY, IIIX 31. Date filed (Month, JAN Day Year) 2008 . Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Patrick O'Leary January 14, 2008 7:20 a M William /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Montgomery General Hospital Olney If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day **Funeral** Months Days Hours **X**□ M 2 □ F 25, 578-30-9893 81 Director 1926 Washington, DC Usual Residence of Decedent 10c. City, Town or Location Show 10a. State 10d. Inside City Limits r 28a-f show notified at 1 □Yes 21 No Directo Maryland Howard Highland 10e. Street and Number 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 13550 Clarksville Pike 20777 USA death \ 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No ģ Specify. 3 ☐ Widowed 4 ☐ Divorced WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry iene. Elementary/Secondary (0-12) College (1-4or 5+) Public Information Official N.A.S.A. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil ment of Health and Mental H ant: If Item 27 is marked oth Jeremiah A. O'Leary Kathleen Tobin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah M. O'Leary/Wife 13550 Clarksville Pike, Highland, MD 20777 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6 18, permit. Page Department of Important: If any injury or Jan. Louis Cemetery St. 2008 Clarksville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. sumpaullume 500 University Blvd, W., Silver Spring, MD 20901 Part1. Enter the or ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) res Pi **Physician** car /Medical Due to (or as a consequence of): Examiner DCI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or us a consequence of) requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical era IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ate has been signed by the atterpage 2 should be detached for a in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 No 1∏ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Injury at Work? Certification: 5 Pending investigation 1 Natural Injury To the Hospital or Attendil within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 📡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MC, H,) B) 0/ Ulney, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 1 6 2008 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland		rtment of H			iene g. No. 2 0 0 1	02542
	Physicia	an	Decedent's Name (First, Middle, Last) MELVIN RENO	POOLE				2. Date of Death Month JANUARY		3. Time of Death
	/Medic	al -	4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Deat		4c. County of De	
	Examin	er		ORIAL HOSPITAI		FREDER]			FREDERI	
	Funeral		5. Social Security Number 6. Sex		st birthday)	If Under 1 Year Months Days			9. F	Sirthplace (State or Foreign Country)
E.	Director		Usual Residence of Decedent	46	Yrs.			May 1,	1961	Maryland
	/land ow et		10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits
	a-f sh	ctor	Maryland Frederic	k Fred	erick					1 X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	eath w	eral	214 Linden Avenue	2. Was Decedent Ever in U.S	13 V		703	inggify Vos or No	United S	tates
	fter de r item	Funeral	11. Marital Status 1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 No		Vas Decedent of Hi Yes, specify Cuba		to Rican, etc.)	Black, W	
15-0036	ours a ral", o Exan	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2፟X No	Specify:		Specify:	White
<u>7</u>	"natu	letec	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give I	ent's Usual Occupa kind of work done of OO NOT use retired	luring most of wo	rking	16b. Kind of Busines	ss/Industry
212	l withii jiene. r than the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	mo: 2	Helper	,		Shelter Worksho	n
Maryland 2121	thould be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural" or items 23a or 28a-f show matte event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)			Trouber	18. Mother's Nar	me (First, Middle, N		
<u>X</u>		10	Unknown				Maryann			
a Z	12 s har 7 is trau		19a. Informant's Name/Relationship (Typ	,					City or Town, State	, ,
ē,	s 1 and if Health item 27 other tr		Susan Holton/ Frier 20a. Method of Disposition	20b. Pla	620-1	S <u>Kesearc</u> sition (Name of natory or other plac	h Drive,		ck, Mary 1. 20c. Location - City	
Ē	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	/	Cremator	!	17/08	Frederick	Maryland
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License		/ \$22 St	Name and Addres	s of Facility uneral H	ome P. A.	roderron	, Ilai y Lang
_	20 = @ 9		Suall VI	Mym	16	521 Oposs	umtown F	ike, Fred	derick, M	D 21702 Approximate
	N		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final	e cause on each line.	Do not ente	er the mode of dying	g, such as cardia	c or respiratory arre	3 51,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseque	ence of):	4/20	we			yr-
	Examiner		Sequentially list conditions, b	wenta	1	e tan	latin	1		yn
1180	ed sit	iner	cause. Enter Underlying	Due to (or as a conseque	nice of j.					
	execut n and al-tran	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
8/60	death certificate be executed e attending physician and id for use as the burial-transit	dical l	d							
RG X	ertifica ing ph e as th	Med	IF FEMALE:							
X P Q	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
j.	the ache	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown		(4,550,7)				
ρ, J	w requires that the s been signed by th should be detache	by P	Part II. Other significant conditions con	tributing to death but not result	ing in the ur	nderlying cause give	en in Part I.			to the cause of death?
ecords,	requir een si hould	ted						1 □ Ye		Probably 4 ☐ Unknown
S Y		Completed						24a. Was ar autops perforn	n 24b. Were y prior ne h ? death	autopsy findings available to completion of cause of
			25. Was case referred to medical				26 Place of De	1 Yes 2 ath (Check only one	No 1 □Y	es 2□No
	≥ .g p	To Be	examiner?	ospital: 1 ☐ Inpatient 2	R/Outpatien	t 3 DOA Othe)F:		nce 6 □Other (S	pecify)
n or	ding Ph h. After th funeral		27. Manner of Death 1 DNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe ho	w injury occurred	
UNISION	Attend death. ctor; / y the f	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At hom building, etc. (Specify)	ne, farm, stre		Yes 2 □ No	28f. Location (St	reet and Number or	Rural Route Number,
2	alor A s after al Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)				City or Town	, State)	
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After ti completely filled in by the funeral	Medical (29a. Certifier (Check only one) CertifyIng Phys	ician: To the best of my know ner: On the basis of examination	ledge, death on and/or inv	occurred at the tin restigation, in my o	ne, date and plac pinion, death occ	e, and due to the ca urred at the time, d	ause(s) and manner ate and place, and o	as stated. due to the cause(s)
	To the within To the comply	Me	29b. Signature and title of certifier	1		29c. License	0 - 1	/	9d. Date signed (Mo	
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8			30. Name and address of person who co	11100		•	7	110 Free 3	reiole Me-	ylan d 21702
3	Sta	te	31. Date filed (Month, Day, Year)	32. Segistrar's Signatu	2 A	Ollas John	TOOK DIT	ve, rrede	ELICK, Mal	.yıan u 21/02
	Registr	ar	IAN 1 8 20	08 Bleeve &						

State of Maryland / Department of Health and Mental Hygiene 2 🕦 🕦 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Robert Charles Powell January 13, 2008 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 7628 Miller Fall Road Montgomery Derwood 8. Date of Birth (Month, Day, Feb 24, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 XM 2 □ F 216-34-4520 70 1937 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~~ " any injury or other traumatic ever." 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Derwood Maryland Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20855 7628 Miller Fall Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Never Married 2 Married 1 □ Yes 2 🕱 No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Design Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Elizabeth Millar Marion Otis Powell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7628 Miller Fall Road, Derwood, Maryland 20855 Sandra Virginia Powell (Wife) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place)
All Souls January 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 16, 2008 Germantown, Maryland Cemetery 22. Name and Address of Facility DeVol Funeral Home, 10 East 21. Signature of Funeral Salvic Deer Park Drive, Gaithersburg, MD 20877 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or learniallure. List only one cause on each line. Approximate Interval Betw Onset and Death Imm diate us 4 inal disease or condition resulting in death) **Physician** Aspiration Pneumonia /Medical Due to (or as a consequence of): Examiner Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) attending physician Physician/Medical the asn 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an completely filled in by the funeral director, page 2 a autopsy performed certificate 1∐ Yes 2☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2∏ No 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 1 Inpatient Certification: To this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred H fter or Attending (Month, Day Year) Injury 1 X Natural 5 Pending investigation 1 □ Yes 2 □ No death. 2 Accident To the Hospital or Attend within 24 hours are death To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 14, 2008 D62435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sayed M. Elsayyad, M.D., 9715 Medical Center Drive, #201, Rockville, MD 20850 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 15 2008 Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** ADELINE. MARY PINO JANURY 2008 20:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 20,1913 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 X F 94 161-10-7856 Italy Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2 X No Director MD Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or the Medical Examiner must be 20886 19109 Caprhart Drive United States death v Funeral tems 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 6 Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White þ 3 Widowed 4 □ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry filed within 72 (Give kind of work done during most of working life, DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 s 1 and 2 should be filed w f Health and Mental Hygier tem 27 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Guistano Perazza Theresa Muse traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau Maria Pino Kingston (Daughter) 19109 Capehart Dr. Montgomery Village, MD 20886 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) January Holy Cross Cemetery 2008 Yeadon. PA 21. Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme late Cause (Final disease or condition resulting in death) **Physician** Abundually Left Pleubal papusing day /Medical Due to (or as a consequence of): Examiner Escherichia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine certificate be executed ASPIRATION PREUMONIA and burial-trai Due to (or as a consequence of) Box 68760. physician Physician/Medical DEMENTIA ears the as attending IF FEMALE: Jse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the (9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 2 X No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy certificate 2 No 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: or Attending Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death. 24 hours after death e Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ပ 2

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State Registrar

31. Date filed (Month, Day, Year)

JAMIE

15 JAN 2008



Morres

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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00065830

JANUARY 13 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11 2008 JANUARY /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number (State or Foreign **Funeral** 1 M 2 □ F Days Months Director NOV. 25, 1932 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Items 23a or 28a-f show Examiner must be notified at 1 Ves 2 No Director Talbot STON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 13. Was Deceden If Yes, specity 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2 No Black þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Process! -ood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event Be Bowser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) School Rd. Cambridge, MD. 2161-3
Date | 20c. Location City or Town, State heona Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 118/08 Chapel 4 Donation 5 Dother (Specify) Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funekal Home, P.A.

Sio washing ton St. Cambri

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. dge, MD, 21613 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AJCVD **Physician** 1 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine -transit law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760 physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death P.O. the detached 9 Unknown 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No certificate has 1□ Yes Division or Vital Hospital or Attending Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 XER/Outpatient 3 DOA 70 After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No death. To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 the 29d. Date signed (Month, Day, Year) 29b. Signature H5049) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOLISHING MD 21801

Registrar

State

JAN 16 2008

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31. Date filed (Month, Day, Year)



100 E. CAKKOU

State of Maryland / Department of Health and Mental Hygienery 1 - State Registrar Certificate of Death Reg. No. 1. Degedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** COBERT KODGERS 08 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1278 Robert Road Crownsville Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 170-12-4132 91 Director 09/20/1916 Glasgow, PA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21032 USA 1278 Robert Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No <u>\$</u> Specify: White d other than "natural", event, the Medical Exa 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Mechanic Metro 27 Is marked other er traumatic event, tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental Rodgers Esther 2 **Hamilton** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Rodgers 1278 Robert Road Crownsville, MD 21032 permit. Pages 1 and Department of Health Important: If item 27 any injury or other troonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Cedar Hill Suitland 01/14/2008 4 ☐ Donation 5 ☐ Other (Specify) Suitland,MD Hardesty Funeral Home P.A. 12 Ridgely Ave Ann, MD 21. Signature of Funeral Service Licenses Tata 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician GO DAY TRUCE /Medical Due to (or as a consequence of): Examiner ear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a I□Yes 2□No 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Unknown 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No dire ဥ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Atter 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 445 DEFENSE Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 5

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Carrie Mae Russell 21:43pM 12 2008 01 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** N.C. Days 1 ☐ M 2**X** F 08/29/29 579-34-0487 78 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 XYes 2 No Washington None Directo DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or USA 20010 5326 Rock Creek Church Road ms 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or Items 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🗽 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: <u>ş</u> Black 3₩idowed 4 Divorced Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12th other 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) is 1 and 2 should be fill of Health and Mental Hitem 27 Is marked oth other traumatic even Be Virginia McQueen P Robert Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Teri Russell Salley Daughter 3404 Brinkley Rd #102 Temple Hills, Md item 27 other t 20c. Location - City or Town, Stat 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State Glenwood Cemetery 01/10/08 Washington, DC 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Snead Mortuary Service, P.A. 21. Signature of Funeral Service Licensee 1409 Fairlakes Pl Ste B Mitchellville, Md Approximate 721 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner law requires that the death certificate be executed that initiated events resulting in death) Last physician and s the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy atter for u in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a o 9 Unknown 9 Unknown Δ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No has e 2 page certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Mnpatient 2 ER/Outpatient 3 DOA P this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After or Attending **X**□ Natural Injury 5 Pending within 24 hours after ucc...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0064588 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashish Tolia, M.D. 1500 Forest Glen Road Silver Spring, Md 20910 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 16 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

08-00670 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 02548 William Cecil Rhinaman State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day January 24, 2008 **Medical Examiner** 0506 hrs WILLIAM CECIL RHINAMAN 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Frederick Memorial Hospital **Erederick** Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign WEST Days Hours Director CountryVIRGINIA 1 X M 2 F 1975 217-08-1941 32 Yrs MARCH 1. Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Yes 2 X No MARYLAND WASHINGTON KNOXVILLE death with the Maryland Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 19111 VALLEY OVERLOOK COURT 21758 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 X No Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify: WHITE δ, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) other than "the Medical E College (1-4 or 5+ I and 2 should be filed within 72 21215-0036 12 LINESMAN ELECTRIC UTILITY CO. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be CHARLES WILLIAM RHINAMAN DIANNE MARIE AULT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is n injury or other traumatic 19111 VALLEY OVERLOOK COURT, KNOXVILLE, MD 21758 TARA A. RHINAMAN/SPOUSE of Health 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, crematory or other place) Pages 1 X Burial 2 Cremation 3 Removal from State 1/28/2007 BROWNSVILLE, MARYLAND Denation 5 Other Specify. BROWNSVILLE HGTS CEM. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7606 Old national Pike BAST FUNERAL HÖME Paul M. Dean Boonsboro, Maryland art I. Enter the diseate, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Cardiac arrhythmia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): cardiomegaly Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine left ventricular hypertrophy (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED #PI_liane_a-c,27 perME,g877, attending physician or use as the burial -Y UNPENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Records, P.O. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? page ✓ Yes 2 1 V Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Other₄ Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 After this 1 V Yes No 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 X Natural death. Pending Yes 2 the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

the Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

OCME

29d. Date signed (Month, Day, Year)

January 25, 2008

and manner stated

Assistant Medical Examiner

32, Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State Registrar one)

29b. Signature and title of certifier

Zabiullah Ali, M.D.

31. Date filed (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary	yiana .		rtment d tificate d				giene Reg. No	7 111	08	02	549
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fijury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 22 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:			Yes, specify			nican, etc.)		Specify: V	_{White, ∈} Vhit		
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	and 2 sealth ar		Kevin Sayers, hus			15 K	line B	lvd.,	Frede						
Baltimore,	Pages 1 nent of He ant: If iten ary or oth		20a. Method of Disposition XXBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Hemovai from State			sition (Name of natory or other ivet C		ry Jan.	. 29, 2		ocation - Cit Fred	•		D
Balti	permit. Departr Importa any Inju		21. Signature of Foreral Service Licen	M , n	MOO2:	55 1	Name and A eeney 06 Eas	and E	Basford Irch St	PA Fur	nera leri	1 Home	21	701	
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Vita	siclan certifii rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient	۵۵۵۵	NO stration	t 3 DOA	Othori	Place of Death				(O "		
7 O.	ng Phy ter this neral di	n: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Y		Bb. Time of Injury		Injury at Work?	☐ Nursing Hor	28d. Describe			-	"	
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2.	Medical C	29a. Certifier (Check only one) 1 ★ Certifying Ph 2 ★ Medical Exam	ysiclan: To the best of niner: On the basis of example and manner stated	xaminatior	edge, death n and/or inv	occurred at t	the time, da my opinior	ate and place, and death occurr	and due to the ed at the time,	cause(date ar	s) and mann nd place, and	er as st d due to	ated. the cause	(s)
	To th within To th comp	Me	29b. Signature and title of certifier	0	M (`	29c. Li	icense num				ate signed (
			P (w. 11)	Yan	71. <u>[</u>)	2-1-4	UI	6675		7	MN.	6,	2008	
	15		30. Name and address of person who can have the can have	GALOR	1)	24NS L		M	D 2	1716					
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	s Signatur	e	all and								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 1^{Day}, 2008 Physician Elizabeth E. Smith 6:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Crownsville Fairfield Nursing Home Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 👿 222-14-2760 81 **Director** March 22,1926 Delaware Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Delaware Kent Smyma 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 North Main Street 19977 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Associate Editor Publishing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental F Be Samuel Ennis Dorcus Deakyne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ,1 and 2 st /f Health ar / item 27 is Creadick Smith/Son 120 North Main Street, Smyma, Delaware 19977 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of He permit. Pages Department of Important: If it 1√Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) any injury or Old Fellows Cemetery: 1-16-08 Smyma, Delaware 19977 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of 2973 Solomons Island Road, Edgewater, Md. 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or sé a consequence of) Examiner and certificate be execu Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for 1 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No page 2: certificate has Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4)X1 Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 😿 No 1 | Inpatient 2 ER/Outpatient 3 DOA P After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and thie of ce 29d. Date signed (Month, Day, Year)

(H) 12 State

Registrar

DHMH 17 Rev 1/2001

erson who completed cause of death (Item 23a) (Type, Print)

5

egistrar's Sigrature

31. Date filed (Month, Day, Year, State **3 0 MAL** Registrar

29b. Signature and title of certifier



MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29d. Date signed (Month, Day, Year)

PARKWAY GREGEBELI MARYLADED

			For State RegisMAEND#7&8, per	State FH , 1/18/08	of Ma	ryland 1500	d / Depa <i>Cei</i>	artmen rtificat	t of H e of L	ealth a Death	and M	lental Hy	giene Reg. No.	200	8	025	552
	District in		1. Decedent's Name (First, Middl									2. Date of De Month	ath Day	Yea		3. Time of E	Death
	Physici Medic	_	Albert H. Small			_						January	_		21	10:05	a^{M}
	Examin		4a. Facility Name (If not institution	n, give street and	number)			4b. City,	Town, or	Location of	of Death		4c.	County of D	eath		
		3	7119 Braeburn Plac						hesda					tgomery			
	Funeral		5. Social Security Number	6. Sex 1 M 2 □ F			ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	<i>y</i> , Yea <i>r)</i> ⊥	919	Birthpla Counti	ace (State or ry)	Foreign
ale	Director		132-03-5310 Usual Residence of Decedent			37 88	3 115.					Dec. 02,	1920	- Ne	ew Y	ork	
	land Sw		10a. State 10b. County		T	10c. City	, Town or Lo	cation							10	d. Inside City	y Limits
	Mary -f sh	호	MD Montgon	ne r v		Bethe	acda									1 ☐ Yes	2₹ No
	r 28a	Director	10e. Street and Number	.029		DCLIN	CDUU	10f. Zip	Code				10g. Citiz	en of What	Counti	ry?	
	h witl 23a o st be	a D	7119 Braeburn Plac	e				20	817				USA				
	deat	Funeral	11. Marital Status	12. Was D	ecedent E	ver in U.S	S. 13. \			spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		4. Race - A			
0	after or ite		1 Never Married 2 Married	ried 1 ☐ Ye	s 2 No	0		1		Specify:		riicari, etc.)	- 1	Black, W			
2-0036	ural",	d by	3 Widowed 4 Divorced	Year o	r Dates:									Specify: [
Į.	"natı	Completed	15. Deceden (Specify only highe	t's Education st grade complete	d)	- 1	16a. Deced	dent's Usu kind of wo	al Occupa rk done d	ation <i>luring mos</i>)	t of worki	ing	16b. Kir	nd of Busine	ss/Indu	ıstry	
N	withir ene. than	d L	Elementary/Secondary (0-12)		e (1-4or 5+	-)				,			U.S.	Govern	ment	t	
N D	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ither than "natural" or items 23a or 28a-f show ent, the Medical Examiner must be notified at		17. Father's Name (First, Middle,		<u>i+</u>	l	Ecc	nomis	<u> </u>	18. Mothe	er's Name	(First, Middle,					
and	d be ental ked o	To Be	William Small							Rebece		Jaffa		ŕ			
<u> </u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparament of Health and Mental Hygiene. Deparament of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations	hip (Type. Print)			19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	al Route Numb	er, City or	Town, State	e, Zip (Code)	
Z	alth a 27 is 27 is ir tra		Jeffrey R. Small /	'Son			171 Dr	uid Da	rive,	McMuri	ray,]	PA 15317					
e G	s 1 s of He item		20a. Method of Disposition			20b. Pl	lace of Dispo emetery, crer					Date	20c. Lo	cation - City	or Tow	vn, State	
Ĕ	Page nent ant: II ary o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		m State					1	n. 14	, 2008	01ney	, MD			
Бапптог	permit. Departr importa any inje		21. Signature of Funeral Service	Licensee 11		7	22	. Name ar	nd Addres	s of Facilit	Mine	s-Rinaldi	Fune	ral Hom	ne,]	inc.	
D	20 5 6 9		Kalphe	Wille	un	2-71						., Silver		ng, MD	2090)4	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications the only one cause o	at caused t n each line	the d eath e.	n. Do not ent	er the mod	le of dying	g, such as	cardiac (or respiratory a	rrest,			Approximate Interval Betw	/een
	Physician	Ì	Immediate Cause (Final disease or condition	Non-	Hodgki	ins Ly	mphoma									Onset and Do	eam
	/Medical Examiner		resulting in death)	Due	to (or as a	consequ	ience of):										
	被	-	Sequentially list conditions,	b. Anem	i i.a to (or as a	consequ	ience of):								-		
	nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Seps		consequ	ierice oi).										
,	execu n and ial-tra	Exa	that initiated events resulting in death) Last	U	to (or as a	consequ	ience of):								+		
200,	cate be executed physician and the burial-transit	dical		d													
Ŏ	certificate nding phys use as the																
ŏ	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome p			Ectopic p	regnancy				2	3d. Date of		,	
	0 00	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	egnant at t			Other (st						Month	L	Day Yo	ear
č	nat the d by t etach	Phy	9 ☐ Unknown Part II. Other significant conditi			t not recu	ultina in the u	adorh ing a	auga giua	on in Dant I		220 Did t	obo ooo	an anntaibus	. 40 40.0	e cause of de	anth O
Š,	The law requires that the di te has been signed by the angle 2 should be detached	þ	Fait ii. Other significant conditi	ons contributing to	dealii bui	i not resu	nung in the ui	idenying c	ause give	m m raiti	•					ibly 4√⊡Ur	
ecords	requ	eted															
e E	2 8 3	Completed										24a. Was		24b. Were prior death	to com	sy findings a pletion of ca	vailable use of
	n: Th ficate r, pag		65 W									1□ Yes	2 🖾 No	1 🗆 Y		2□No	
	Attending Physician: The law redeath. recept. After this certificate has to by the funeral director, page 2 s	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☒ No	Hospital:	- Innetion		ED/Outration	4 2 D	Othe			(Check only o		-			
5	Phy rrthis eral di	\vdash	27. Manner of Death	28a. Da	te of Injury	/	ER/Outpatien 28b. Time of		28c. Injury Work	4∐Nu ≀at		me 5 🔀 Resident			pecify)	1	
5	th.	tior	1 XNatural 5 ☐ Pendir 2 ☐ Accident investi	19 1 '	onth, Day	Year)	Injury	м		:? ∕es 2 🗌	No						
<u> </u>	Atter	ifica	3 Suicide 6 Could 4 Homicide determ		ace of injur ilding, etc.	ry - At hor	me, farm, str	eet, factor	, office			28f. Location (S			Rural	Route Numb	ber,
5	tai or s afte al Dir	Certification:	4 - 110 molec		nang, etc.	Opecny	7					City or Tou	vii, State)				
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical		ng Physician: To Examiner: On the and m		examinat)
	To the To the CODE	Me	29b. Signature and title of certifie	r					. License				_	e signed (Mo			
	7		156	~				HO	05512	5			Janua	ary 13,	200	18	
	1		30. Name and address of person Katherine E. David						1149	, Chev	y Cha	ise, MD 2	0815				
	Sta Registr	-	31. Date filed (Month, Day, Year) JAN 1	5 2008	. Pojistrar	r's Signat	ture	house	,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day **Physician** TERRY PAULETTE STEPP JANUARY .2008 /Medical 10:00p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Institutes of Health Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 46 237-17-9738 April 5, North Carolina Director 1961 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits show other traumatic event, the Medical Examiner must be notified at Director NC Henderson Hendersonville 1 ☐ Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 28792 USA 292 Hobe Crest Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. and tem 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: 3 Widowed 4 Divorced White ed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Complete (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unemployed None 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Stepp Maxine Case 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hendersonville, NC 28792 292 Hobe Crest Road Maxine Stepp/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01-06-2008 Hendersonville, NC Shepherds Park 22. Name and Address of Facility Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4217 9th Street, NW Washington, DC 20011 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Klebsiella septic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner neutropenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed acute leukemia attending physician and for use as the burial-tra resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident (Month, Day Year) Injury 1 ☐ Yes 2 ∏ No Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral
completely filled 29a. Certifier critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number.
Massachwsetts License 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

JASON ELINOFF

31. Date filed (Month, Day, Year)

JAN 0 8 2008

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10 CENTER DRIVE .

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BETHESDA, MD 20892

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** January 7, 2008 9:30 a M Earl Reece Stadtman /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Director 88 557-28-9821 15, 1919 New Mexico Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo Derwood Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20855 United States 16907 Redland Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Caucasian þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Biochemist Biomedical Research 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Ethyl Reece ဂ္ဂ Walter William Stadtman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16907 Redland Road, Derwood, Maryland 20855 <u>Thressa C. Stadtman - spouse</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) <u>Lincoln Crematory</u> 1/17/2008 Brentwood, Maryland 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. E use the discrete shock, / In art fail ur. Immediate C == e (Final disease or condition resulting in death) e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. **Physician** Malignant Arrhythmia /Medical Due to (or as a consequence of): Examiner Atherosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Year 5 Other (specify) 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ☐ ER/Outpatient 3 X DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760 al or Attending P after death. I Director: After I d in by the funera completely filled in by To the Hospital or within 24 hours afte To the Funeral Di

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Yogin Patel 31. Date filed (Month, Day, Year)

JAN 15 2008

9901 Medical Center Drive, Rockville, Maryland 20850

and manner stated.

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D00065955

29d. Date signed (Month, Day, Year)

1/7/2008

			1- State of Maryland State of Maryland		artment of Hortificate of L		Mental Hy	giene Reg. No.	00	8 02555
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Dorathy Freund Simmons				2. Date of Domestin	Day	Yea 08	3. Time of Death 8:15 A. ^M
	Examir		4a. Facility Name (If not institution, give street and number) 524 Hawkesbury Lane 5. Social Security Number 6. Sex 7. Age (In yrs. la	est hirthday)	4b. City, Town, or Silver S			4c. C Mo	ounty of De	eath
	Funeral Director		052-38-7511 1□ M 2\ F 95	Yrs.	Months Days	Hours Min.	JAN. 2	ay, Year)	(Country)
	Maryland I-f show fied at	tor		Town or Loc						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the 3a or 28a	I Director	10e. Street and Number 524 Hawkesbury Lane	er spi	10f. Zip Code 20904				ed St	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	H	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Decify	o- 14		nerican Indian, nite, etc.
21215-0036	vithin 72 hou ene. han "natura e Medical E:	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	(Give I life. E	lent's Usual Occupa kind of work done di OO NOT use retired)	uring most of work	king	16b. Kind	of Busines	
	be filed writal Hygie d other t event, th	Be	17. Father's Name (First, Middle, Last)	Home	emaker	18. Mother's Nam	e (First, Middle	1	Home urname)	
Maryland	2 should and Men is marke aumatic	은	Joseph Freund 19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a	Edna Roi nd Number or Ru		per, City or T	own, State	, Zip Code)
nore, N	ages 1 and nt of Health : If Item 27		1 ☐ Burial 2 🛣 Cremation 3 🛣 Removal from State Metr	ace of Dispos	lawkesbury sition (Name of natory or other place tan		Silver Date			20904 or Town, State
Baltimore,	permit. Pa Departme Important any Injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Ruin Millu M01508	eral S Th	ervice Name and Address Nibadeau N 33 Gist Av	s of Facility Mortuary	/2008 Service	e. P./	١.	a. VA
TO MAN TO STATE OF	Physician /Medical Examiner	ler	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Final to only its cause (Disease or injury) Due to (or as a consequence cause (Disease or injury)	Do not ente	er the mode of dying	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death 5 Years
68760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	ince of):						
P.O. Box	the death certifi y the attending iched for use as	Physician/M	!F FEMALE: 23c. If yes, outcome pf pregnant in the past 12 months? 1 ☐ Yes 2 In the past 12 months? 1 ☐ Yes 2 In the past 12 months? 9 ☐ Unknown 4 ☐ Pregnant at time of dear on the pregnant at time of the pregnant at tim	death 3 🗆	Ectopic pregnancy Other (specify)			230	d. Date of d Month	lelivery Day Year
rds, P	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not result Depression	ing in the un	derlying cause giver	n in Part I.				to the cause of death? Probably 4 □Unknown
Vital Records,		Completed						psy ormed? 2 No	prior to death?	autopsy findings available o completion of cause of ? es 2 □ No
Division or Vit	ding Phys n. After this funeral di	ation: To Be	1 X Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	R/Outpatient 28b. Time of Injury	Other	4 LI Nursing Ho		dence 6 [pecify)
Divis	ital or Attender or after death ral Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At hom building, etc. (Specify)				City or To	wn, State)		Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in L	Medical	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowl and manner stated.	edge, death on and/or inv	estigation, in my op	inion, death occur	and due to the red at the time	date and p	lace, and d	ue to the cause(s)
	[Ò O	2	29b. Signature and title of certifier	MD	29c. License			29d. Date :		nth, Day, Year)
			30. Name and address of person who completed cause of death (Item 2 Irnest S. Oser, M.D. 10301 Geor	gia Av	ŕ	304 Sil	ver Spr	ing, N	1D 20	0902
	Sta Registr	_	31. Date filed (Month, Day, Year) JAN 1 5 2008 32 Aegistrar's Signatu	re da	ules		_			

State Registrar 31. Date filed (Month, Day, Year) JAN 15 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

aniedosek

29b. Signature and title of certifier



29c. License number

D006

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 15, Dorothy Virginia Schaake 9:30 a. M January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 5504 Bonnie Brook Road Dorchester Cambridge If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 200 F Yrs 579-42-3308 73 **Director** Maryland July 1. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f shov notified at 1 ☐ Yes 2 ☐ No Dorchester MD Cambridge Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 5504 Bonnie Brook Road 21613 USA Funeral 14. Race - American Indian, Black, White, etc. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 2 white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) law office 12 secretary permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic event 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Wiltshire ပ္ Martha Dunn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald E. Schaake husband 5504 Bonnie Brook Rd., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 1/22/08 Hurlock, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastetic OVERIGE Concer **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) detached Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2☑No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ပို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 atural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated.

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician:

State

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

503 BYRN ST

32. Restrar's Signature

29b. Signature and title of dertifier

THANWY

MOMAN

31. Date filed (Month, Day, Year)

29c. License number

CAMBRIDGE

D47924

29d. Date signed (Month, Day, Year)

1-16-08

21613

MD

			For State Registrar	State of Maryla		artment of F rtificate of		Re	g. No.	02558
1990 1	ysicia /ledica	n al	1. Decedent's Name (First, Middle, Las LARRY SPENC	ER				2. Date of Death Month	Day 11 2008	
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Maryland 1 show			17 - 50 - 9659 11	10c.	City, Town or L	ocation rnie, Aj	pt. #E,	SEPTEMBER MD	28,1948	Maryland 10d. Inside City Limits X Yes 2 No
h with the	at to not	al Director	10e. Street and Number 399 Lenlow	Court		10f. Zip Code	21225	10	g. Citizen of What Co	untry?
3-0030 72 hours after death with the Maryland natural, or Items 23a or 28a-f show	Examinerma	by Fur	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No II Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub. 1 Yes 2 No		Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: B	e, etc.
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should be filed and Mental Hygic	9 1	To Be (17. Father's Name (First, Middle, Last) Phillip I. Spe		40. 14.		Unkr			
	other traumetic		19a. Informant's Name/Relationship (7 Keren Spencer/ 20a. Method of Disposition	Sister	81 W		St., E	ottstow	City or Town, State, Z	464
Definit. Pages 1 as Department of Hea Important: If item	ō		1 Burial 2 Cremation 3 4 Nonation 5 Other (Specify 21. Signature of Juneral Service 1.	Removal from State	cemetery, cre ward U	matory or other place Iniv.C o 2. Name and Addre	f Med.	wastin Ro	ashingtory yster Fur W., DC 20	n, DC neral Hom
Physic /Medi Exami	ical		23a. Part1. Enter the disease, or comp shock, or Fart failure. List only of Immediate Callut (Final disease or condition resulting in death)	a	ASTON				st,	Approximate Interval Between Onset and Death
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E 2	8 3	2	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause giv	ren in Part I.	23e. Did toba	cco use contribute to	the cause of death?
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Hospital or Attend 4 hours after death Funeral Director:	completely filled in by the	Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	ecify)	,		City or Town,		
the Hospital hin 24 hours a	iletely ti	3	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medicel Exam	rsician: To the best of my liner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	e, and due to the cau urred at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
To the within 2	dwoo	Me	29b. Signature and title of certifier	Wallan	in	29c. Licens	3113L	J 290	Date signed (Month	11, 2008
			30. Name and address of person who c	ompleted cause of death (I LACE VMD 32 Registrar's Sig	tem 23a) (Type,	Print) KULE	BRIDE F	Lo, Bri	TIMORE,	md 212
Red	State		31. Date filed (Month, Day, Year)	32 Registrar's Sig	gnature &	andi i		,	,	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		,	Certificate	of Death		Reg. No	2008	025	59
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	Mary f sho	ō	WV Min	eral	Bu	rlington					1 ☐ Yes 2	2 🕅 №
	r 28a	Director	10e. Street and Number			10f. Zip Co	ode		10g. Ci	tizen of What Cou	intry?	
	h with		HC 84, Box 9	1-A		2	26710			USA		
	deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Deceden	nt of Hispanic Origin? (Cuban, Mexican, Pue	Specify Ye	s or No-	14. Race - Amer Black, White		
5-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ፟፟፟፟ Marrie 3 ☐ Widowed 4 ☐ Divorced		No	1 □ Yes 2 📉				Specific.	White	
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att	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service L	Licensee / _	1	22. Name and	Address of Facility			. Main S		
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			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each li	d the death. Do r ne.	ot enter the mode of	of dying, such as card	iac or respir	atory arrest,		Approximate Interval Betw Onset and De	reen eath
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	To the Hospital or Attend' within 24 hours after death. To the Funeral Director; / completely filled in by the fi	Medical C	29a. Certifier (Check only one)	ng Physician: To the best Examiner: On the basis of and manner st	of examination an	e, death occurred at d/or investigation, in	the time, date and plan n my opinion, death o	ace, and du ccurred at t	e to the cause(ne time, date a	s) and manner as nd place, and due	stated. to the cause(s))
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7	đ		30. Name and address of person	who completed cause of	death (Item 23a)	(Type, Print) 9()	4 Setor	Dri	ve s	wte	203	
	P		Qamar W	Zaman 1	MD	Cu	mberl				02	
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ستين	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs		If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Vear)	9. Birth	place (State or Foreign
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_	uld be f Mental H Irked of Itic eve	To Be	William Joseph Toomey Sr.			Florence				
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type. Print) Amanda Kathleen Gartner/Daught	er 627	g Address (Street an Cypresspo	ointe Dr	al Route Number ive Seve	r, City or Tow erna Pa	n, State, Zij ark , M	D 21146
Baitimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 Burial 2 A Cremation 3 Removal from State		sition (Name of natory or other place) ematory	Jan. 2008	18,	20c. Location Baltin	-	own, State Maryland
Salt	Departm Departm Mporta Iny inju		21. Signature of Funeral Service Ligensee	/ IB	. Name and Address arranco &	Sons, P	.A. Seve	erna Pa	arķ Fu	neral Home
21			23a. Part 1. Enter the disease, or complications that caused the dea		95 Gov. R				ark, M	Approximate
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	IN THE	ىر	30. Name and address of person who completed cause of death (Ite	23a) (Type,	Pefense	Hwy, (roft	on, 1	no :	21114
	Sta		31. Date filed (Month, Day, Year) JAN 1 5 2008 32. Figistrar's Sign	nature		, ,				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 2008 8, 6:43pm An Minh Truong Tang January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gaithersburg Montgomery 18409 Hallmark Court If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖺 F Yrs. 75 Vietnam Director Oct. 5, 1932 220-94-5300 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2X No Director Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 3 must be n 18409 Hallmark Court Funeral 20879 United States r than "natural", or items: the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: Completed by Asian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Clerk Electronics permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Toan Truong Sinh Dang P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11121 Maryland Manor Court, Germantown, MD 20876 Derek Tang (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NAtional Memorial Park 1/11/08 Falls Church, Virginia 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Fune al Service Licenart1. Enter tile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List only one cause on each line. Approximate Interval Between Onset and Death I mediate Cau e (Final dis no er ndition resulting in death) **Physician** Metastatic Non-Small Cell Lung Cancer 18 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usesase or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: ise (23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown þ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a Was an autopsy performe certificate 28 No 1□ Yes Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Medical Certification: To this funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Jopital C. 4. Hours after dec. Temeral Director: After decidents of the fundamental decidence of the fu 1 XNatural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hou. the Funeral Direc. اعلام الم 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Medical Dector D64677 January 9, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 N. Broadway, Baltimore, MD 21231 Arati Desai, M.D. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 5 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 [] [] ? 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** January County of Death 235 PM entance 8005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 ATS.

Dave Hours Min. Monta Health Care Confe 11/500 due v 9. Bitthplace (State or Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 579-60-3598 1 ☐ M 2 💢 F 89 Director CT May 4,1918 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits I Health and Mental Hygiene. Item 27 Is marked other than "neturel", or Itema 23e or 28a-f ehow other traumetic event, if a Medical Exacid at marative inclined at 1 ☐ Yes 2 🔯 No Director Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Russell Avenue 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "neturel", or ite 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No þ Specify: 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) D.C. Metropolitan Police Elementary/Secondary (0-12) College (1-4or 5+) Police Women 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harold Lee Tilley Rose Mildred Carver 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Franklin / Cousin 181 Pokorny Road , Higganum, CT 06441 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ō 1 XBurial 2 ☐ Cremation 3 XRemoval from State permit. Page Department o Important: If eny injury or once. January 16 4 □ Donation 5 □ Other (Specify) Ashland Cemetery 2008 Ashland, ME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 1 RACULA STUCK 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): g physician and as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical for use as the ed by the attending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) cate has been signed by page 2 should be detack Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes To the Hospital or Attending Physicien: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 ို 1 Yes 2 No Narsing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Natural 5 Pendina within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number 22m 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 251 Russell World Freubers 20877 Day, Year) 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

Examiner the death certificate be executed Division or Vital Records, P.O. Box 68760. attending physician for use as the buria page 2 this Hospital or Attending

Certification: death. Director: after To the Hospital within 24 hours a To the Funeral C Medical

Funeral

Director

show

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

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permit. Pages 1 and 2 should be filed Department of Health and Mental Hygik Important: If Item 27 is marked other 1 any Injury or other traumatic agent 1

Physician

/Medical

Injury or other traumatic event,

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State JAN 1 5 2008 Registrar

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0064058

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Sear d /Medical Name (I not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death ounty of Death If Under 1 Year | If Under 24 Hrs. | Hours | Min. last birthday Birthplace (State or Foreign Country) **Funeral** Days Director Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at MDSomerset Crisfield Director 1 ☐ Yes 🏋 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 320 Pine St. 21817 Funeral USA items Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or item edical Exaπiner n Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite ury or other traumatic event, the Medical Examine. 1X Yes 2 No 1944— If Yes, Give Year or Dates: 1966 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cryptologist Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Issac Thomas Ward Emma Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trainonce. Eleanor K. Ward Wife 320 Pine St. Crisfield, MD 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 1/15/2008 Baltimore, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service License Jak 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Depoic Shock /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to infilterate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed nterocutaneous attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atten e detached for u 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4 Cunknown page 2 should Completed Halungen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Delydration 1 2 No 25. Was case referred to m ical examiner? Be 26. Place of Death Check onl or Other: 4 Nursing Home 5 Residence 6 Other (Specify) (2)X(10) ည 1 ☐ Yes 102 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Records, P.O. Box 68760, Division or Vital

ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t Certification: completely filled in by the Medical within 2

31. Date filed (Month, Day, Year) State Registrar JAN 1 5 2008

29a. Certifier

30. Name and

(Check only one)

29b. Signature and title of certifier

Mon

Herbert

ress of person who completed cause of death (Item 23a) (Type, Print) 300 32. Raistrar's Signature

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DOD 433

Medical

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year JANUARY 5th Mary Nevada Wagstaff 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9-15-1939 9. Birthplace (State or Foreign Country) 1 □ M 2 🗙 F Months Days Hours Min. 68 233-62-7149 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ▼ Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 54th St. SE 20019 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 f Yes, Give 2 X No 1 ☐ Yes 2 ☒ No Specify Specify: Black 3 ☐ Widowed 4 X Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Med. Tech. Health 18. Mother's Name (First, Middle, Maiden Surname) Quillar Mae Scales

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

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'natural', or items 23a or dical Examiner must be

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Injury or Important: If any injury or once,

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should be filed within 72 hours after and Mental Hygiene. marked other than "natural", or ite

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Pages 1 and 2 ment of Health a

3altimore, Maryland 21215-0036

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Box 68760. certificate be P.0. or Vital Records, Division To the Hospital or Attending death. Il Director: / within 24 hours a

To the Funeral I

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Registrar

31. Date filed (Month, Day, Year) JAN 0 8 2008

32. Registrar's Signatu

Completed 12 17. Father's Name (First, Middle, Last) Be Amos Jones ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven E. Wagstaff/Son 4230-B Indianhead Hgwy., Indianhead, MD 20640 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crem. 1-10-08 Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Rd., Brentwood, MD 20722 Comme 23a. Part1. Enter the disease, or complications in at aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Co 11 LARBIOPULMOnary disease or condition resulting in death) hour, Due to (or as a consequence of Pneumenia Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Bronchogenic Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼ No 24a. Was an autopsy 1∐ Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes %Z No 1 opatient P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) D52865 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael 3001 HOSpits

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 12:44 a M January 4, 2008 Catherine B. Wade /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 XF Yrs. Director Suffolk, Va. 225-60-6770 Feb. 17, 1944 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1x Yes 2 □ No Maryland Prince Georges Forestville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or edical Examiner must be United States 20747 1218 Iron Forge Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ <u> High School Counselor</u> Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Catherine Daniels Charlie Byrd 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Alphonso Wade, Jr. /Spouse 1218 Iron Forge Rd. Forestville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any injury or o
once. 1[™] Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Jan.10,2008 Landover, Md. 22. Name and Address of Facility
Alexander S. Pope P.A.
5538 Mariboro Pike/Forestville, Md. 21. Signature of Funeral Service License 20747 23a. Parti. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multina Advanced Unknown /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performed? 2 X No the Hospital or Attending Physician; filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🔀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ٩ 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Registrar

31. Date filed (Month, Day, Year)

JAN 0 8 2008

29b. Signature and title of certifier

ROINTAN



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License numbe

4344

29d. Date signed (Month, Day, Year) 1.4.08

Silver Spring MD 20902

			1 - For State Registrar	State of Maryland / De	epartment of Heal Certificate of Dea			. No.	02367
	Physici /Medic		1. Decedent's Name (First, Middle, La Lillian	Ruan	Wil		2. Date of Death Month anuary	Day Year 15 2008	3. Time of Death 2:00 P M
2.62	Examin		4a. Facility Name (If not institution, given Golden Living Co	enter	4b. City, Town, or Loca Frede	rick		4c. County of Death Freder	ick
	Funeral Director			Sex 7. Age (In yrs. last birth: 1 □ M 2 🕱 F 80 Yr	Months Days Ho	ours Min.	B. Date of Birth (Month, Day, Y Dec. 18,	rear) 9. Birth Cou	place (State or Foreign ntry) Maryland
	death with the Maryland ms 23a or 28a-f ehow Fraust be notified at	ctor	10a. State 10b. County Maryland Freder	ick Frede					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with the	Directo	10e. Street and Number	_	10f. Zip Code	2	10g	g. Citizen of What Cou	,
		by Funeral	10608C Bethel R 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Oad 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Yes 2 12 No If Yes, Give Year or Dates:	21702 13. Was Decedent of Hispan If Yes, specify Cuban, Me 1 ☐ Yes 2☒ No Sp	ic Origin? (Spec exican, Puerto Ri	rfy Yes or No- ican, etc.)	United S 14. Race - Ameri Black, White, Specify: Whi	can Indian, etc.
21215-0036	within 72 hours after ene. than "naturel", or Ite te Medical Examina	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during fe. DO NOT use retired)	most of working	9 16	6b. Kind of Business/Ir	ndustry
land 21	be filed within tal Hygiene. d other than "	Be	7 17. Father's Name (First, Middle, Last		Homemaker 18.1		(First, Middle, Ma		
2	2 should be and Mental is marked c	ဠ	Peter Isaac Gil 19a. Informant's Name/Relationship		failing Address (Street and N		uan Stul Boute Number, C		p Code)
ге, ма	is 1 and 2 should of Heelth and Men Item 27 is marke other traumatic		David L. Wiles /	Son 1053	38 Powell Road isposition (Name of crematory or other place)	d Thurm	iont, Mai	ryland 217	88
Бант	permit. Pages 1 end 2 Department of Heelth a Important: If Item 27 is eny injury or other tra		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Signature of Puneral Service Lice	(h) Resthau	en Mem Garden 22. Name and Address of	Facility Stau	2008 Fr iffer Fur	neral Home:	s, P.A.
	death certificate be executed Wedical Water transit After use as the burial-transit	edical Examiner	23a. Part1. Enter the disease of the shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of Due to (or as a consequence	NFAMCTI ALLURE	ch as cardiac or			Approximate Interval Between Onset and Death DAYS
C. BOX	attending for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliv Month	very Day Year
ecords, P.	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions	contributing to death but not resulting in t	ne underlying cause given in	Part I.		cco use contribute to	
Hec	The la ete has page 2	Completed					24a. Was an autopsy performe	24b. Were aut prior to co	opsy findings available ompletion of cause of
N I I I	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	0.500		(Check only one)		
DIVISION OF	ding h. After fune	ation: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigated	28a. Date of Injury (Month, Day Year) 28b. Tin	ne of 28c. Injury at	28	e 5 Residen	ce 6 □Other (Speci rinjury occurred	ify)
DIVIS	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filted in by the funerel	Certification:	3 Suicide 6 Could not to determined		n, street, factory, office	28	Bf. Location (Stre City or Town,	net and Number or Rui State)	ral Route Number,
	To the Hospital o within 24 hours af To the Funerel D completely filled in	Medical	(Check only 2 Medical Exa	hysician: To the best of my knowledge, miner: On the basis of examination and/ and manner stated.	or investigation, in my opinior	n, death occurred	d at the time, date	ise(s) and manner as e and place, and due d. Date signed (Month	to the cause(s)
)	o T will	-	29b. Signature and-title of certifier	-40	29c. License nun			DI - 16 - DERICK IM	
	V			completed cause of death (Item 23a) (T	TOLL Hous	E AUE	- FRED	PERICK M	0.21701

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 8 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Dora WEITZMAN January 13, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Takoma Park Sligo Creek Nursing Center Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) June 1923 Days Hours Months 1 □ M 2**/**□ F 84 Min. 579-26-2479 <u>Washington,</u> Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1 ☐ Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? United States 1131 University Blvd., W., #1505 20902 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. White 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Musa Edlovitz Joseph Edlovitch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20902 1131 University Blvd., W., #1505, Silver Spring, MD Harry Weitzman, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 01/16/08 Judean Memorial Gardens Olney, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part1. Enterthe Hease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Years Immediate Cause (Final disease or condition resulting in death) Olivopontine Cerebellar Degeneration Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? res 2 \ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical **Examiner** Examiner Physiclan: The law requires that the death certificate be executed

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event once.

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

ģ

Completed

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

and burial-tra Physician/Medical

attending physician for use as the hurial funeral director this After

Completed

Be

Certification: To

Division or Vital Records, P.O. Box 68760

Hospital or Attending

death.

24 hours after deatl

within 2.

filled in by

IF FEMALE: 23b. Was decedent pregnant 9 Unknown þ

> Other: 40X Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work?

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29b. Signature and title of certifier

29c. License number D 22309

29d. Date signed (Month, Day, Year) January 15, 2008

30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

8712 Maywood Avenue, Silver Spring, MD 20910 Phillip W. Poth, M.D.,

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar 31. Date filed (Month, Day, Year)

JAN 15

5 Pending investigation

6 ☐ Could not be determined



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Julia Jean Waters рм /Medical January 14 2008 8:26 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 W F Director 339-09**-**4954 90 3, 1917 Illinois Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at be notified Director 1 ☐ Yes 🔏 🙀 No Maryland Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code within 72 hours after death with ō 9500 East Light Drive "natural", or items 23a 20903 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White à 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 sho. Id be filed within ment of Health and Nental Hygien. ant: If Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Dorchik Sophia Micek of Health and N Item 27 is man other trauman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bernard J. Waters/ Husband 9500 East Light Drive, Silver Spring, MD 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important; If It any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 19, 4 □ Donation 5 🖾 Other (Specify) entombment Gate of Heaven Cemetery 2008 Silver Spring, Maryland 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee Wanner 500 University Blvd, W., Silver Spring, MD 20901 28a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Congestive Heart Failure /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical the as attending plant of the last 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate 2**√** No 1□ Yes To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Txtxx 2 1 X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

State Registrar 29b. Signature and title of certifier

Irina Ruban, MD

31. Date filed (Month, Day, Year)

JAN 16

DHMH 17 Rev 1/2001

1500 Forest Glen Road, Silver Spring, MD 20910

29c. License number

D63343

29d. Date signed (Month, Day, Year)

January 15, 2008

and manner stated.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

State of Maryland / Department of Health and Mental Hygien 02570 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** 15,2008 0130 ANUARY Peter Zmitrovich /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sandy Spring Montgonery Brooke Grove Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Davs Hours Months t√□ M 2□ F Director 83 Oct. 19, 1924 New York 109-18-7986 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23e or 28e-f shov The Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Silver Spring Montgomery 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 15311 Beaverbrook Court, 3H USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 □ No Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White WWII þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen. Important: If item 27 is marked other the any injury or other treumatic event, Insu. once. Engineer Structural 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Constantine Zmitrovich Elizabeth Shlopak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Zmitrovich/Wife 15311 Beaverbrook Court, 3H, Silver Spring, MD 2090 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 16 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a ACUTE MYOCARDIAL IN FARCTION MINUTES Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ng physician and as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Lue to for as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No VASCULAR DEMENTIA Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 X No 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 5 Other (Specify) 355 St-d ۵ 1 ☐ Yes 2 X No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation s after dean. el Director: Aftr 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funerel Dil completely filled in 29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier TWO Attending Physician IDXI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grace Brook Huffman, M.D. 18100 State School Road Sardy Spring, Maryland 2086 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

JAN 16 2008

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 30 Month **Physician** ATKINS ARGARET january 08.30AM 2008 /Medical 4a. Facility Name (If not institution, give street and number Examiner HOSPITAL HOSPICE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 M 2 F 171-18-0701 Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov be notified at 1 ☐ Yes 2 ☐ No Funeral Director 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ò offee Tree Court 23a ortant: If Item 27 is marked other than "natural", or Items 23s injury or other traumatic event, the Medical Examiner must Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify: Black Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) condary (0-12) College (1-4or 5+) Beautician and Mental Hygiene. 12th grade 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Be 2 permit. Pages 1 and 2 sho Department of Health and Important: If Item 27 Is many injury or other traum: 19b. Mailing Address (Street and Num 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City 1 Burial 2 □ Cremation 3 □ Removal from State 2/6/08 Restland Lincoln Man Monroeville 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn c. Breene Cuneral STVCS 21. Signature of Funeral Service Lice s 8728 Liberty Rd. Randallstown, MDZ1133 M01401 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as care liac or respiratory arrest, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final DEM ENTIA **Physician** ADVANCED disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ENDOMETRIAL MASS BLEEDING VAGINAL 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 No TO THRIVE 24a. Was an autopsy performed? 1□ Yes 210 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No HILLURG 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1. Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide the Hospital 1 🔼 CertifyIng PhysIcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO 30 2008 054288 30.-Name and address of person who completed cause of death (Item 23a) (Type, Print) Rangaragan Hamaswamy 32. Registrar's Signature 31. Date filed (Month, Day, State 0 1 2008 FEB Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			a FOI	artment of Health and Me artificate of Death	ental Hygien Reg. N	2008 02572
, de	Dhoolai		1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
No.	Physici /Medic		Hilda Augu		January 3	$0, 2008 10:01 P^{M}$
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
-	samanan	*	3944 Link Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs. 8	Date of Birth	Baltimore 9. Birthplace (State or Foreign
н	Funeral Director		206-16-4828 1 M 2 T F 83 Yrs.	Months Days Hours Min.	B. Date of Birth (Month, Day, Yea Oct. 8, 1	924 Pennsylvania
20			Usual Residence of Decedent		JCC. 0, 1.	
	larylan show	_	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	ne Ma 8a-f s	Directo	9	timore		1
	with th	Dir	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	eath v	eral	3944 Link Avenue	21236 Was Decedent of Hispanic Origin? (Spec	ifu Voc or No	U.S.A. 14. Race - American Indian,
10	fter d	Funeral	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto R	ican, etc.)	Black, White, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Exarriner must be notitled at	by	3 Mary Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: White
5-0	72 hc 'natuı dical	Completed	(Specify only highest grade completed) I (Give	edent's Usual Occupation e kind of work done during most of working	16b.	Kind of Business/Industry
121	vithin ne. han " e Me	ld m	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Orus Iloma
	filed v Hygie ther t		12 17. Father's Name (<i>First, Middle, Last</i>)	Homemaker 18. Mother's Name (Own Home
Maryland	should be f and Mental I s marked of umatic eve	o Be	Robert Walburn	Vern	_	0.77
Z	2 shoul and Me is mark	우		ing Address (Street and Number or Rural		
	1 and 2 Health a em 27 is ther tra		Carol A. Augustine Daughter 394	4 Link Avenue Balt	imore, Ma	ryland 21236
J.	8 = = 0		20a. Method of Disposition 20b. Place of Disposeriery, cre	osition (Name of Da ematory or other place)	te 20c.	Location - City or Town, State
Ē	Pages ment of I ant; if Ite ury or of			d Cemetery 2-2-2	1	ltimore Maryland
Baltimore,	permit. Pages 1 and 3 Department of Health Important; if Item 27 any Injury or other tro		21. Signatura of Funeral Service Libensee	22. Name and Address of Facility Ruc 1050 York Road		Funeral Home, Inc. aryland 21204
	2 X 3		23a. Part1. Enter the disease, or complications that caused the death. To not shock, or heart failure. List only one cluse on each line		-	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition)		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	1 /.		>5/4/
	Lammer	<u>.</u>	Sequentially list conditions, b. Due to (group a state of the state of	V		
	ted nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	()		
,	icate be executed physician and the burial-transit	Examine	that initiated events resulting in death) Last c. Due to (or as a contequence of):	P		
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_	tificat ig phy as th	ledi	10/00	1000		
Вох	death certific e attending p id for use as	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□Live birth 2□Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
		Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year
P.0	The law requires that the de ate has been signed by the a bage 2 should be detached f	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23a Did tobacco	o use contribute to the cause of death?
ds,	signe	l by	art in Outer argument conditions continuing to death but not resulting in the	underlying cause given in Fait i,		2 No 3 Probabiy
Sor	v req beer shou	etec			24a. Was an	
Records,	The lav	Completed			autopsy	24b. Were autopsy findings available prior to completion of cause of death?
Vital			25. Was case referred to medical	26. Place of Death	performed?	No 1 ☐ Yes 2 ☐ No
N.	Physician: this certificated director, I	To Be	examiner? 1 Yes 201 No Hospital: 1 Inpatient 2 ER/Outpatie	Other:		6 ☐Other (Specify)
וס ר			27. Manner of Death 127. Manner of Death 128a. Date of Injury (Month, Day Year) 13. Injury 14. Injury 14. Injury 15. Injury 16. Injury 17. Injury 18. Inj	of 28c. Injury at 28	3d. Describe how in	
<u> 0 </u>	Attending r death. ector: After by the fune	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division	or Att fter de Direct n by 1	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	Bf. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	pital ours a eral D		29a. Certifier Certifying Physician: To the best of my knowledge, dea	ith populated at the time, date and place a	ad due to the source	(a) and manner as stated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or i and minner stated.	investigation, in my opinion, death occurre	d at the time, date a	and place, and due to the cause(s)
	To T To 1	Σ	29b. Signature and title of certifier	290 License number	29d. [Date signed (Month, Day, Year)
	~			104 UT 76	1 .	-3/20
	10		30. Name and address of person who complete sause of death (Item 23a) (Type A YMAN F, AKKAD), 7600 OSLER	DR,#411, Towson, I	MD 2/2	204
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Arrest)		
E.	Registr	ar	FER O T SAINS	1		ı

			1 - For State Registrar	State of	f Marylar	nd / Depa	artment of F	lealth and Death	Mental Hy	giene () () (3 02573
* *5	- 5169.	ń	Decedent's Name (First, Middle, I	ast)			timodito or	- Journ	2. Date of De		3. Time of Death
196	Physici		Yvonne (nmn) A	_					Januar	y 25, 200	
	/Medic Examir		4a. Facility Name (If not institution, g		mber)		4b. City, Town, o	r Location of Dea		4c. County of I	
			411 Sugarberry	Ct.			Edgewo	ood		Harf	ord
	Funeral	П	Social Security Number 6	Sex	7. Age (In yrs.	,,	If Under 1 Year Months Days	If Under 24 He Hours Min		th 9.	Birthplace (State or Foreign Country)
	Director		231-14-2228	1□M 2 [F	86	Yrs.				3, 1921	Pennsylvania
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Manyl	ō	Maryland Ha	ford							1 ☐ Yes 2√∑No
	28a-	Director	10e. Street and Number	LOIG		ECC	gewood 10f. Zip Code			10g. Citizen of Wha	at Country?
	3a or	0	411 Sugarber	v Ct.			210	140		USA	
	ma 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13. \			(Specify Yes or No orto Rican, etc.)		American Indian,
36	be filed within 72 hours after death with the Maryland nat Hygiene. Ind other then "natural", or flems 23a or 28a-f ehow event, the Mudical Examinar must be notified at	y Fur	1 Never Married 2 Married	Armed Fo 1 ☐ Yes If Yes, Gi	2 ∑ ₹No ve		fYes, specify Cuba I□Yes 25xNo	an, Mexican, Pue Specify:	erto Rican, etc.)	Specify:	White, etc.
21215-0036	hours tural'	ed by	3 Widowed 4 □ Divorced	Year or D	ates:	160 00000					White
75	n 72	Completed	15. Decedent's (Specify only highest of			(Give	lent's Usual Occup kind of work done o DO NOT use retired	ation during most of w d)	orking	16b. Kind of Busin	ess/Industry
112	within iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		ice Assis			Health (Jaro.
	e filed within al Hygiene. I other then vent, the Ma	Be C	17. Father's Name (First, Middle, La	st)			12022		ame (First, Middle,	Maiden Sumame)	Jaic
Maryland	should be nd Mental marked o	To B	Harvey (UNK)	Harmon				Mildre	ed (UNK)	Watson	
Jar	fa E E		19a. Informant's Name/Relationship				-			er, City or Town, Sta	
ď.	of Health of Hea		Linda A. Baker/	Daugnte			Sugarber	ry Ct.,	Edgewood	d, MD 2104	
יסר	ages if the		20a. Method of Disposition 1 Burial 2 Coremation 3		State	cemetery, cren	natory or other place			20c. Location - Cit	
Baltimore,	permit. Pages 1 Department of H Important: If Its any injury or ot once.		4 □Donation 5 □ Other (Special Signature of Fundral Service Lice		<u> </u>		Service C		28-08	Towson, N	Maryland
Ва	Depi impo	. 3	Mully 11	buch		Mc	COmas Fu	neral H	ome, P.A.	ion, MD 21	1009
W.			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that of	aused the deat			1.00			Approximate Interval Between
B	Physician		Immediate Cause (Final disease or condition			tive -	Heart	- Fail	une		Onset and Death
1	/Medical Examiner		resulting in death)	Due to	(or as conseq	quence of);	Heart	0			
	Lxammer	_	Sequentially list conditions,		or as a conseq		thery	Vise	ase		
a .	nsit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	546 (0	(OI as a COIIS OC	querice or).	36.01				
120	execu in and ial-tra	Examin	that initiated events resulting in death) Last	c Due to	(or as a conseq	quence of):					
8760,	cate be executed physician and the burial-transit	dlcal		d							
89	ntiffica ng ph a as th	Med	IF FEMALE:								
Box	eath certific attending p for use as	lan/I	23b. Was decedent pregnant in the past 12 months?		come of pregna eirth 2 🗆 Feta		Ectopic pregnancy	,		23d. Date of Month	f delivery Day Year
0	he dea	Physician/Me	1 Yes 2 No	4□Pregr 9□Unkn	ant at time of down	death 5□	Other (specify)			Widitii	Day Toal
مَ	res that the de signed by the a be detached t		Part II. Other significant conditions	contributing to d	eath but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contribu	te to the cause of death?
of Vital Records,	90	d by	Hyperte	work					101	res 2 □ No 3 [Probably 4 Unknown
00	law requires as been si 2 should i	olete	Huner li	ordon	200				24a. Was		e autopsy findings available
æ	The lavate has	Completed	7,000						autop perfo 1 ☐ Yes	prior prior deal	th?
ita		Bec	25. Was case referred to medical examiner?					26. Place of De	eath (Check only o		100 24.10
<u>></u>	S S	은	1 ☐ Yes 2 No			ER/Outpatien	t 3 DOA Cth	er: 4 🗆 Nursing	Home 5 Resid	dence 6 Other (Specify)
n o	ling P	 .:	27. Manner of Death Natural 5 Pending		of Injury th, Day Year)	28b. Time of Injury	28c. Injury World		28d. Describe h	now injury occurred	
isio	Attending ir death. ector: After by the fune	cat	2 Accident investigate 3 Suicide 6 Could not	be 390 Place	of Injuny - At h	ome farm etr	M 1 □	Yes 2 □ No	28f Location /9	Street and Number of	or Rural Route Number.
É	al or Attend after death Director: d in by the	Certification:	4 ☐ Homicide determine	d buildi	ng, etc. (Specit	fy)	set, factory, office		City or Tou		n nurar noute reamber,
	To the Hospital or Attending Phwithin 24 hours atter death. To the Funaral Director: After th completely filled in by the funeral	edical C	29a. Certifier Certifying F	iminer: On the b	best of my kno asis of examina ner stated.	owledge, death ation and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occ	ce, and due to the courred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 %	/	1 1 10	29c. Licens			29d. Date signed (M	
			+ Lu	Mil	4 R	10	D00	392	58	Jay, Z	5,2008
	15		30. Name and address of person wh		e of death (Item	n 23a) (Type, I	Print)	.0.	., .	0 / 11	5,2008 MD 21014
	,			inhite	MO	615	v. Mac	Phail	# 206	Bel AIL	MU 21014
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 1 200	8 32. R	egistrar's Signa	ature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 02574

		1- For State Registrar	Certi	ficate of Deat	h	Reg.	No.	
Physicia		Decedent's Name (First, Middle,Las	t)			2. Date of Death Month	Day Year	3. Time of Death
edical Exami	ner	Javan a	scown			January 15,	2008	2127 hrs
		4a. Facility Name (if not institution, giv Sinai Hospital	e street and number)	4b. City, 1 Baltin	own, or Location of D	eath	4c. County of Death	1
Funeral Director		5. Social Security Number 6. So	/	Month	er 1 Year If Under 24 s Days Hours	4Hrs. 8. Date of Birth	Foreign	thplace (State or gn buntry)
Birostor		Usual Residence of Decedent	M 2 F 5	Yrs.		Q/Q7/	1701	dilay) /UU
nd show any ace.	'n	10a. State 10b. County N/A	10c. City, T	own or Location	2			10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 3902 Penh	urst Ave. A	D-A 10f. Zip	H215	10g	Citizen of What Cou	ntry?
ter death wi	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year		ent of Hispanic Origin? fy Cuban, Mexican, Pu No specify:		14. Race - Amer White, etc.	rican Indian, Black, Grican American
6 72 hours after an "natural", cal Examiner	Completed by	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	Lor Dates:		rking life. DO NOT use		16b. Kind of Business	(Industry
5-0036 led within 72 Hygiene. I other than 'the Medical	omo	17. Father's Name (First, Middle, Last)	Labor	Man 18. Mother's N	lame (First, Middle, Ma	CONTY aiden Surname)	WEAU
21215-003 unld be filed withi Mental Hygiene, marked other th	æ	George Lon	9		Ca	rrie ?	Brow	Control of the Contro
and 2 should ten 27 is may ten 27 is may traumatic etraumatic etra	٢	19a. Informan Name/Relationship (*)	n, Dr./Son	19b. Mailing Address 15434	Street and Numbe	r or Rural Route Numb	ser, City or Town, Stat	e, Zip Code) e, WD 21206
7		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	ace of Disposition (Na ematory or other place	4	Date	20c. Location - City o	r Town, State
Baltimore, permit. Pages 1 an Department of He. Important: If ite		4 Donation 5 Other Specify 21. Signature of Funeral Service Licer		een Maria 22. Name and	Address of Facility	2/2/08/	· Greene	almeral sine
Dep Dep Inju		Carl Sand	MOIYOI	8728	Liherte	121. Ra	macesta	My MO 21/33
Physician		Part I. Enter the disease, or comfailure. List only one cause on e			of dying, such as card	lac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
Munical saminer			Aspiration of food bolus Due to (or as a consequence of):					Death
A. Sec.		Sequentially list conditions, b						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of):					
ecuted and and		events resulting in death) Last	Due to (or as a consequence of):					
a a ex	/Medical	UNPENDED	AMENDED					
8760, tificate be ex ng physician as the burial.	ın/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregna	ancy 2 Fetal death	3 Ectopic p	regnancy	23d. Date of deliver Month	Day Year
Box 687 death certificates at the attending part of for use as the	Physiciar	past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at time of dea					
O. Bo at the de d by the tached f		Part II. Other significant conditions		sulting in the underlyin	g cause given in Part			o the cause of death?
S, P.O Jires that to a signed by doe detac	ed by	Acute alcohol intoxication	<u></u>			_		obably 4 Unknown
of Vital Records, ng Physician: The law require After this certificate has been si meral director, page 2 should b	Completed					24a. Was a autops perforr	y prior to	autopsy findings available ocompletion of cause of
tal Rec cian: The certificate ector, page	Con				00 Di (D	1 ✓ Yes 2	No 1 🗸	Yes 2 No
ital ician s certi recto	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ✓ I	ER/Outpatient 3	26.Place of Death (Cl		Residence 6 Oth	er:
of V ing Phys After thi	-: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred	-
ion (tendine eath.	ation	1 Natural 5 Pending 2 ✓ Accident Investigat	(Month, Day yeár) Jan 15, 2008	0000 hrs	1 Yes 2 🗸 N	Subject chok	(ea	
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certificate busins after death. Funeral Director: After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use as	Certification:	3 Suicide 6 Could not determine	t be 28e. Place of Injury - At hor	me, farm, street, factor	y, office building, etc.	or Town. St		Rural Route Number, City e, MD
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical Co	29a. Certifier 1 Certifying Physic	cian: To the best of my knowledger: On the basis of examination an	e, death occurred at th	e time, date and place by opinion, death occu	e, and due to the cause rred at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
To the within 2 To the complet	/led	29b. Signature and title of certifier	and manner stated.		c. License number		29d. Date signed (M	
		For the A	ey Mo		O.C.M.E.		January 16, 20	08
5		30. Name and address of person who	completed cause of death (Item :		Street, Baltimore	MD 21201		
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur			, 1110 2 1201		
Regis		FEB 01 a	2008	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Jan. 31^{y} Physician 2008° 7:15 A M Louis John Breitenother, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 2, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Days 1 M 2□F Months Min. 1926 Maryland 81 219-22-5627 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 No Parkville Maryland Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or Items 23a or United StatesOfAmerica 21234 8820 Walther Blvd. Apt. 4110 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) © ivilian Employed Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Materials Specialist 8 US Chast Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Matilda Johanna Lang Frederick Charles Breitenother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8820 Walther Blvd. Apt. 4110 Parkville, MD., 21234 19a. Informant's Name/Relationship (Type. Print) Florence Breitenother Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sykesville, Maryland Feb. 4,2008 Lake View Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS FUNERAL CHAPEL & CREMATION 8800 Harford RD., ParkvilleMD., 2 N SERVICES 21234 Dachetel Tatriciaami 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Ulmonava years /Medical Due to (or as a consequence of) Examiner BES TOS 409VS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for auta consequence of Due to (or as a consequence of): burial-1 physician Physician/Medical the aftending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the

State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

DANIGUE

6565 MD DORERMAN 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

29c. License number

harles

29d. Date signed (Month, Day, Year)

ST. SUITE 209 BALTIMORE, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 30TH 2008 5:37PM Grace T. Brown JANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Apr. 14, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1 □ M 2XX Months Days Hours 212-30-9691 Director 74 1933 Maryland Usual Residence of Decedent 10c. City. Town or Location 10a, State 10h Counts 10d. Inside City Limits 1 Yes 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 9951 Oaklea Court 21042 Funeral of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes XX No by Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Secretary Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph H. Thomas Clair B. Kessler ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau 9951 Oaklea Court, Ellicott City, Maryland 21042 Albert Brown (Husband) Date 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Feb. 7, Garrison Forest 1XXBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Veterans Cemetery Owings Mills, Maryland 21. Signature of Funeral Service Licensee Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Road, Owings Mills, MD 21117 23a. Part1. Ev er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner BREAST CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 ☐ Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð NEMTA 1 | Yes 2 | No 3 | Probably 1 | Unknown Completed FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1□ Yes , 2□ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes | 2 ☐ No ᇋ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Alatural 5 | Pending investigation M 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 141) 19 asuma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20

DHMH 17 Rev 1/2001

completely filled in by the

be filed within 72 hours after death with the Maryland ntal Hygiene.

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

al Hygiene.

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Pages 1 and 2 should

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Division or Vital Records,

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After

after death

within 24 hours a To the Funeral L

Attending Physician:

0

State Registrar

31. Date filed (Month, Day, Year)

GLARIMA CHATURVEDI

32. Registrar's Signature

gog SOUTH CATON AVENUE, BALTIMORE, MD, 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / L	Department of Health and N Certificate of Death	Reg. No. 2008 0257
	Physici	_	1. Decedent's Name (First, Middle, Last) Mary L. Brown		2. Date of Death Month Day Year January 28, 2008 1:30AM
	/Medio	1 63	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Carriage Hill Bethesda	Bethesda	Montgomery
	Funeral Director		5. Social Security Number 479-22-4994 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last bit) 82	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) May 10, 1925 9. Birthplace (State or Foreign Country) I owa
	yland now at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location	10d. Inside City Limits
:	e Mar a-fsl	cto	Maryland Montgomery	Bethesda	1 ☐ Yes 2 X No
3	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath w		5015 Battery Lane #1004	20814	United States
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I feel file that so a consistence of the than "ratural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Specify:
215-0036	2 hour latural ical Ex	ted k		. Decedent's Usual Occupation	White 16b. Kind of Business/Industry
1215	filed within 7 Hygiene. ther than "n int, the Medi	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired) Registered Nurse	Health Care
d 21	filed with Hygiene. ther than		17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)
an	ould be i Mental arked o	To Be	Harold D. Lamb		Jesse Woodroffe
Maryland	2 should and Men Is marke aumatlc	ř		D. Mailing Address (Street and Number or Rui	ral Route Number, City or Town, State, Zip Code)
	1 and 2 Health a em 27 Is ither trai		Dean K. Brown/ Husband 50	015 Battery Lane #100	4, Bethesda, Maryland 20814
e e			20a. Method of Disposition 20b. Place of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State	f Disposition (Name of	Date 20c. Location - City or Town, State
<u>H</u>	Pages ment of h ant: If ite		4 Donation 5 Other (Specify) of He	eaven Cemetery (30).	2008 Silver Spring, Marylan
Balt	permit. Page Department of Important: If any Injury or once,		21. Signature of Fueeral Service Licensee M00335	22. Name and Address of Facility Rob Bethesda-Chevy Chas Bethesda, Maryland	ert A. Pumphrey Funeral Home/ e. Inc. 7557 Wisconsin Avenue 20814-3501
Er.	LET		23a. Part1. Enter the disease or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest, Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition resulting in death)	ICULAR FIBAL.	LLATION Onset and Death
	/Medical Examiner		Due to (or as a consequence	of):	£1::125
	KIM I	į.	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence		TAILCICE
P.	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
0,4	exec		resulting in death) Last Due to (or as a consequence	of):	
68760,	ficate be executed physician and is the burial-transit	edical	d		
			IF FEMALE:		
Вох	leath certif attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death	h 3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery Month Day Year
P.O.	that the de ned by the a detached i	ıysic	1 Yes 2 Ano 9 Unknown 9 Unknown	3 Gottor (appearly)	
S, P	8 5 8	by Pr	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
ord	w require been sig should b	ted			
Records,	The law ate has b bage 2 sh	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2
			25. Was case referred to medical	26 Place of Doo	1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ Yes 2 ☐ Yes 2 ☑ Yes 2 ☐ Yes
or Vital	Physician: this certific ral director,	o Be	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 EP/O	Lou	ome 5 ☐ Residence 6 ☐ Other (Specify)
ō	<u>a</u> = <u>a</u>	n: To	27. Manner of Death 28a. Date of Injury 28b.	Time of 28c. Injury at Injury Work?	28d. Describe how injury occurred
io	Attending F r death. ector: After by the funer	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	
\leq	al or Atte s after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, f building, etc. (Specify)	arm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge Medical Examiner: On the basis of examination a and manner stated.		, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			Imagero, MD	D005713	1/29108
_	12		30. Name and address of person who completed cause of death (Item 23a)		
	,		Truong Bao. M.D. 9715 Medical Cer	nter Drive #201, Rock	ville, Maryland 20850
	St. Regist	ate rar	31. Date filed (Month, Day, Year) 1 2008 32. histrar's Signature		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:20 PM 29, 2008 January Marjorie Jeanne Brett /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Rockville Nursing Home If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F 89 June 12, New York Director 125-12-5867 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show be notified at 10a State 10h County 1 Yes 2 No Director Chevy Chase Montgomery Maryland 10a, Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a 20815 United States 3513 Leland Street **Examiner must** Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married 'natural", or 1 ☐ Yes 2 🛣 No Specify: White Specify. þ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States College (1-4or 5+) Elementary/Secondary (0-12) the Department of the Navy Code Room Tech marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) in and 2 should be fill Health and Mental H tem 27 is marked ott Jeanne Madeleine Staebler Albert F. Hess 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any injury or other trau 3513 Leland Street, Chevy Chase, Maryland 20815 Elizabeth G. Brett / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 31. 1 ☐ Burial 2 St Cremation 3 ☐ Removal from State 2008 4 Donation 5 Dother (Specify) Bethesda, Maryland Montgomery Crematorium 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M01473 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Hypertensive Heart Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequents of Examiner burial-transi Congestive Heart Failure Due to (or as a consequence of) Physician/Medical Atrial Fibrillation the, as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1∐ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification:

and physician attending

Box 68760,

P.O.

Division or Vital Records.

with the Maryland

72 hours after death

Saltimore, Maryland 21215-0036

has

funeral director, spital or Attendi lours after death. neral Director: A death. To the Hospital or within 24 hours af To the Funeral D

Medical

1 X Natural 2 ☐ Accident

3□ Suicide

29a. Certifier

4 ☐ Homicide

(Check only

29b. Signature and title of sertifier

5 Pending investigation 6 ☐ Could not be

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29c. License number

D0047330

29d. Date signed (Month, Day, Year) January 30, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Momen

Thomas Joseph, M.D. 50 West Edmonston Drive, #207, Rockville, Maryland 20852

31. Date filed (Month, Day, Year) State Registrar FEB 01



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

Physicia /Medic Examino	in al er
Funeral Director	
e, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director

F	hysicia		Decedent's Name										Month	Day	2008		:00 PM	1 M
	/Medic	al	Frank T 4a. Facility Name (/	ucker_	Bobst	(number)			4b. City, T	own or	Location o	of Death	Januar	-	County of De		•00 In	1
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s afte	ral", or items 23a or 28a-f show Examiner must be notified at	by F	1 ☐ Never Mari 3 ☐ Widowed			es 2 □ s, Give or Dates:	142 – 44	. 1	1 ☐ Yes 2	∏ No	Specify:				Specify:	whi	.te	
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in 72	edic fedic	olet		cify only highe	est grade comple	ted) ge (1-4or !	5.)	(Give life. L	kind of wor OO NOT us	k done d e retired	during mos)	t of work	ing					
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E E	othe ent,	BeC	17. Father's Name	(First, Middle	, Last)						18. Moth	er's Name	e (First, Mide	dle, Maiden	Surname)			
ald be	rked tlc e	To B	Frank	Tucker	Bobst S	r						_	e Hard	_				
shot N	s ma		19a. Informant's N										al Route Nui					
and 2	27 i er tra		Ron Bar	ber/ex	ecutor						1gow		et Phi					
es 1 s	roth		20a. Method of Dis		3 □Removal f	rom State	COL	ace of Dispo metery, crer	sition (Nam matory or o	ne of ther plac	e) :		Date	20c. Lo	cation - City	or Tow	n, State	
Pag	ant: F		4 Donation			Tom Glate	1											
ormit.	Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of E	uneral Service Onald	licensee Wade	Bir	ector	St	2. Name an Cate A	nate	omv B	ity loard	655 V	V. Bal	timore	e St	reet	
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death certificate be executed	attending physician and for use as the burial-transit	Examiner	that initiated event resulting in death)	is .	c	e to (or as	s a conseque	ence of):										
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ath certi	nding use a	N/M	IF FEMALE: 23b. Was decede	nt pregnant			e pf pregnan		⊒Ectopic pr	eananc)				N:	23d. Date of			
death	e atte		in the past 1:	2 months?	4 🗆 1	regnant a	2 □ Fetal at time of de		Other (sp		у			_	Month	ı	Day Ye	ær
The law requires that the	signed by the a be detached f	hys	9 Unknow			Jnknown												ath 2
D, T	gned e det	by P	Part II. Other sign	ificant condi	tions contributing	to death	but not resul	lting in the u	ınderlying c	ause giv	en in Part	1.					e cause of dea	
w requires														☐ Yes 2	☑ No 3[ably 4 □Un	IKHOWII
aw re	as been 2 should	Bet											a	Vas an utopsy	24b. Wer	e autop	sy findings av	vailable use of
r a	ate ha	Completed											1□ Y	erformed?	deat	h? Yes	2□No	
V Ital	s certificate has t irector, page 2 s	Be C	25. Was case refe examiner?	erred to medic								e of Dea	th (Check or	nly one)				
Or VILA Physician:	his ce I dire	10	1 Yes 2	No	Hospital:	1 🗌 Inpat		R/Outpatie			44	lursing H	ome 5□F			Specify)	
	ofter the	1.0	27. Manner of Dea	ath 5 ∐Pend		Date of In (Month, D		28b. Time o Injury		28c. Inju	ryat rk? IYes 2□	7.61-	28d. Descr	ibe how inju	ry occurred			
VISION Attending	tor: A the fu	cati	2 ☐ Accident	inves 6 ☐ Could	tigation	Disease of in	aium, At hou	mo form of	M		res 2L	71/0	28f Locatio	on (Street a)	nd Number o	or Rural	Route Numb	er.
I or Attend	Direct n by	Certification	4 ☐ Homicide	data	mined 28e.	building, e	njury - At hor etc. (Spec <i>ify</i>	me, iaim, si	reet, lactor	y, onice				Town, State		n nunan	Todae Tramb	01,
To the Hospital or	within 24 nous aute boan. To the Funeral Director: After this certific completely filled in by the funeral director,		29a, Certifier	1 Cartifi	Ing Physician:	In the hes	at of my know	wledge, dea	th occurred	at the ti	ime, date	and place	and due to	the cause(s) and mann	er as st	ated.	
Hosp	Fun Fun	edical	(Check only one)	2 ☐ Medic	al Examiner: On	the basis I manner s	of examinat	tion and/or i	nvestigation	n, in my	opinion, d	eath occu	irred at the ti	me, date an	d place, and	due to	the cause(s)	
o the	To the Complete	Med	- 4	nd title of entit		1			29		se number				te signed (A			
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			30. Name and ad	dress of ne	on who complete	cause of	death (Item	23a) (Type	, Printh ~		2	_						
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	St	ate	31. Date filed (Mo			2. Regis	strar's Signal	ture	alf I									
	B		9-1	CD 0 1	2008	30 00	A A TO	100000	San San									

			1- State Amend #31 Per I	of Maryland / De WR G876 2/0				-	_	02580
	Physicia	an	Decedent's Name (First, Middle, Last)				2.	Date of Death	Pay, 2008'	3. Time of Death
	/Medic	al	Kenneth Bowles	umbar)	Ab Ciby To	own, or Location of		anuary	4c. County of Death	10:49 PM
	Examin	er	4a. Facility Name (If not institution, give street and n 1022 Spa Road	umber)	Annar		OI Death		Anne Aru	nde1
	Funeral Director	i i e	5. Social Security Numbeunk 6. Sex 1 M № 1 P	7. Age (In yrs. last birtho	day) If Under 1		Min.	Date of Birth (Month, Day, Y	(ear) 9. Birthp Court 1943 Mary 1	lace (State or Foreign try) and
	2		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location				1	0d. Inside City Limits
	deeth with the Maryland me 23a or 28a-f show must be invitted at	ō			polis					1 □ Yes 2√ No
	r 28a	rect	MD Anne Arunde1 10e. Street and Number	Aima	10f. Zip C	Code		10g	. Citizen of What Cour	ntry?
	238 o	ai D	1022 Spa Road			21401			USA	
	be lied within 72 hours atter deeth with the Marylan Hydjane. Hydjane. Att Hydjane. Ad other than "neturel", or iteme 23a or 28a-f ehow avent, the Medical Examaner must be notified at	by Funeral Director	Armed I	2X No	13. Was Decede If Yes, specif	nt of Hispanic Ori y Cuban, Mexicar No Specity:		Yes or No- an, etc.)	14. Race - Americ Black, White, Specify: W	
200-	2 hou	ted	15. Decedent's Education	16a D	ecedent's Usual	Occupation	et of working	16	6b. Kind of Business/Inc	dustry
7	ithin 7	Completed		(1-4or 5+)		done during mos retired)	st of working		£in -	
V	Hygian Hygian other th	Cor	unk unk 17. Father's Name (First, Middle, Last)			aborer	er's Name /F	irst Middle Ma	farming iden Sumame)	
	ntai H ed of ed of	Be						L. Bur	- 11	
2	s 1 end 2 should be f Heelth and Menta ftem 27 is marked other traumatic av	T ₀	Philip T. Bowles 19a. Informant's Name/Relationship (Type, Print)	19b. N	Mailing Address (City or Town, State, Zip	Code)
E	od 2 :		Hattie A. Morgan/sist	er P	.O. Box	854 Mec	hanics	ville,	MD 20659	
more,	Pages 1 en nent of Hee int: If Item 2 iry or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal fror 4 □ Donation 5 🖾 Other (Specify) in Si	State cemetery.	Disposition (Name crematory or oth	e of eer place)	Date	20	Oc. Location - City or To	own, State
	permit. Pages Department of I Important: If It any Injury or o		21. Signature of Funeral Service Licensee Ronald S. Wade,	rector		Address of Facili Anatomy ore, MD		655 W.	Baltimore	Street
	To the Hospital or Attanding Physicien: The law requires that the death certificate be executed to the Hospital or Attanding Physicien and to the Funeral Director. After this certificate has been signed by the attending physicien and to the funeral director, page 2 should be deteched for use as the burial-transit or property.	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	caused the death. Do no each line. Or as a consequence of or	ARDIA VD	of dying, such as	S cardiac or re	spiratory arres	t,	Approximate Interval Between Onset and Death
O. DOX 0	the death certific y the attending p iched for use as	Physician/Medi	in the past 12 months	utcome of pregnancy birth 2 Fetel death gnant at time of death nown	3 ☐Ectopic pred				23d. Date of delive Month	ery Day Year
ords, r	ures thet signed b	ρ	Part II. Other significant conditions contributing to	death but not resulting in t	he underlying cau	use given in Part I	1.		cco use contribute to the	
Leco	he law red e hes beel age 2 shou	Completed						24a. Was an autopsy performe 1 Yes 2	orior to ∞ death?	psy findings available mpletion of cause of
<u>.</u>	ruficel stor, p	Be C	25. Was case referred to medical			26. Place	e of Death (C	heck only one)		
<u> </u>	nysic his ca I direc	To	examiner? 1 Yes 2 No Hospital:	Inpatient 2 ER/Outp	atient 300A		ursing Home	5 Residen	ce 6 □Other (Specif	(y)
פוסוי	anding P sath. or: After t he funera		1 Natural 5 Pending (Mo 2 Accident investigation	e of Injury onth, Day Year) 28b. Tin Inje	ne of 28 ury M	c. Injury at Work? 1 Tes 2]No		r injury occurred	
	rs effer de et Direct led in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pla buil	ce of Injury - At home, farm ding, etc. (Specify)	n, street, factory,	office	28f.	Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	in 24 hou the Funer plately fil	Medical			or investigation, i	in my opinion, dea		at the time, dat	e and place, and due to	o the cause(s)
	To Con	2	29b. Signature and title of certifier	2 ms	290.	License number	67	290	d. Date signed (Month,	Saur (ear)
			30. Name and address of person who completed ca	donor Hw-	ype, Print)	e,200) (Crott	m (mi)	21114
	Sta Registr		31. Date filed (Month, Day, Year) 34.	Registrar's Signature	1 A. A.	Cost!		U		

TANUARY AC/ES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SALTIMORE
If Under 1 Year | If Under 24 Hrs. SPELIA/TY University 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 219-10-1996 1**∭**M 2□F 60 Director ptenber 25, 1925 Usual Residence of Decedent 10c. City, Town or Location 10b. County sa or 28a-f show t be notified at Director TIMOLE 10e Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or items with highly or other traumatic event, the Medical Examiner must be none. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 11. Marital Status Armed Forces:

1 Mayes 2 No
If Yes, Give 13-27-43

Year or Dates: 10-27-51 BROWN 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of workil
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12+1 18. Mother's Name 17. Father's Name (First, Middle, Last) Be nwar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) AWN CEMETER 21. Sign wre of Funeral Service Licensee 22. Name and Address of Facility LOMPASSIDN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by certificate has page 2 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death

30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)

1. Decedent's Name (First, Middle, Last)

Physician

Tob. County	6	nomit/ac				1 Yes 2 No
ber		10f. Zip Code		10g. C	itizen of What Co	ountry?
Hillsdale Ro	λd	31	207		451	A
12. Was Decede Armed Force	nt Ever in U.S. 1 s?	 Was Decedent of Hi If Yes, specify Cuba 	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
d 2 Married 1 Maryes 2 If Yes, Give Year or Date:		1 ☐ Yes 2 No	Specify:		Specify:	BLACK
5. Decedent's Education only highest grade completed)	16a. De	cedent's Usual Occupa ive kind of work done o e. DO NOT use retired	ation luring most of worki	16b.	Kind of Business	/Industry
lary (0-12) College (1-4c	r 5+)	D. 1	_		C.h.	\
rst, Middle, Last)		r Ast	18 Mother's Name	e (First, Middle, Maide		nsn.
best Brow	اه		Rock	()	MAN	
e/Relationship (Type. Print)	T T	ailing Address (Street a	and Number or Rura			Zip Code)
NA Brown	Wife 321	lakelliH 10	^ ^	Altimore M		D7
sition	20b. Place of Dis	sposition (Name of crematory or other place	1 1		ocation - City or	Town, State
Cremation 3 □Removal from Sta □ Other (<i>Specify</i>)	te \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	IN CEMETER	12-2	-08 N	NWA/boo	MO
eral Service Licensee	Magoria	22. Name and Addres	1			
Ext. Puett. f	~ ·	121-51 LOND	5 STOUR	ier st. Bai	TIMORE, M	10 21723
disease, or complications that causiallure. List only one cause on each	ed the death. Do not line.	enter the mode of dying				Approximate Interval Between
nal	2/101	Acre	A			Onset and Death
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itions b.						
ediate Due to (or	as a consequence of):					
с						
Due to (or	as a consequence of):					
	2 Fetal death at time of death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of de Month	livery Day Year
ant conditions contributing to deat	but not resulting in the	e underlying cause give	en in Part I.	23e. Did tobacco	use contribute to	o the cause of death?
too rend	Dis	: 20		1 ☐ Yes	2 □ M o 3 □ P	robably 4 □Unknowr
over A	ten	Dixo	20	24a. Was an autopsy	prior to	utopsy findings available completion of cause of
below V	hell	+		performed? 1□ Yes 2□	death? 1 ☐ Yes	s 2□No
to medical Hospital:		Otho	Ar'	(Check only one)		
, I larinba		tient 3 DOA Othe	4 Li Nursing Ho	me 5 Residence 28d. Describe how inj		ecify)
5 Pending (Month, I	Day Year) Injui	y Work	res 2 □ No	20d. Describe now inj	ary occurred	
6 Could not be determined 28e. Place of building,	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location (Street a City or Town, Sta	and Number or R te)	lural Route Number,
Certifying Physician: To the be Medical Examiner: On the basis and manner	of examination and/o	eath occurred at the time r investigation, in my o	ne, date and place, pinion, death occur	and due to the cause red at the time, date a	s) and manner a nd place, and du	s stated. e to the cause(s)
le of certifier		29c. License	number	29d. D	ate signed (Mon	th, Day, Year)
is of person who completed cause of	f death (Item 23a) (Typ	pe, Print)	2931	2	1 (8)	
Day, Year) 32. Regi	strar's Signature	[eval-	> Ho	AW.		
0 1 2008	· A A	and the same of th				
		RIGINAL				

State Registrar

0

2 No

1 ☐ Yes

27. Manuar of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only 29b. Signature and title of

31. Date filed (Month, Day, Year)

FEB 0 1

۴

Certification:

Medical

this

After t

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death

2. Date of Death

Year

2008

4c. County of Death

0.750 M

Birthplace (State or Foreign Country)

10d Inside City Limit

State of Maryland / Department of Health and Mental Hygiene 02582 Certificate of Death Reg. No. 4 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 28, MARGARET K. BENNETT **JANUARY** 2008 11:17 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HEARTHOMES LINTHICUM ANNE ARUNDEL Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 Months Days Hours Director APRIL 20, 1916 175.01.0006 91 PA Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a State 10h County ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, The Medical Examiner must be notified at 1 □Yes 2□No Director MD ANNE ARUNDEL CROWNSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 612 TOPLAND DR. 21032 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Montal Hygiene. Important: If Item 27 is marked other than "natural" any Injury or other traumatic. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No þ Specify: 3 Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY KRUPPA ဥ JOHN KORNOSKY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 612 TOPLAND DR. CROWNSVILLE ,MD. 21032 JAMES BENNETT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XX Burial 2 Cremation XX Removal from State 4 ☐ Donation 5 ☐ Other (Spe E VERNON CEMETERY 2.2.2008 BELLE VERNON, PA 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. t/a MARYLAND MORTUARY SUPPORT GREGORY FINK 426 CRAIN HWY S. CLEN BURNIE, MD 21061 M01148 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lly one cause on each line. Approximate Interval Between Onset and Death Enter the disease, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician YEARS** DEMENTIA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 2 Fetal death in the past 12 months? Month Day Year 4□Pregnant at time of death ☐Yes 2☐No 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part, þ 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes XX No 2 No 1□ Yes 1 ☐ Yes Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Wursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 3 DOA Certification: To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Medical

IAN K. SLEPIAN, MD 8028 RITCHIE HWY PASADENA, MD 21122

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Guar mo

31. Date filed (Month, Day, Year) State 0 Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier





🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D33231

29c. License number

29d. Date signed (Month, Day, Year)

JANUARY 29, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician JANUARY 30. 2008 3:05 A CONCETTA M. BELLESTRI /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** HARFORD HART HERITAGE STREET 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F 90 Director 220-12-5357 10, 1917 Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location show 10a. State 10b. County 10d. Inside City Limits notified 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 606 Kilmarnock Trail 21014 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia (unk) Lamanna Anthony (unk) Jeppi or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Margaret T. Vale / Daughter 606 Kilmarnock Trail, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 2-4-08 Baltimore, MD McComas Funeral Home, P.A.

1017 Collegbury Road, Abingdon, Maryland 21009

Approximate 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AL 7 Hermers **Physician** disease or conditior resulting in death) years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 KNo detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been sli Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy 2.2 No 25. Was case referred to medical examiner? Assisted 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No CARR 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. Box 68760, Division or Vital Records, Hospital or A 24 hours after of To the Hospital within 24 hours at To the Funeral C

Director: After filled in by the

🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

39889

29c. License number

29d. Date signed (Month, Day, Year) JANUARY 30, 2008

In mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W. MACPHAIL BUL AIR MOS 21014 ALGRED SPANIS

and manner stated.

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

29a. Certifier

Medical



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ano it bamou		- For State Criticate Certificate	e of Death	Reg.	200	8 0258
Physiciar		tegistrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
ledical Examin	er	Marie Burnett		January 24,	2008	1900 hrs
	r.	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Baltimore	1	4c. County of Death	
		2 North Smallwood Street Apt. 317 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		s. 8. Date of Birth(NA MM/DD/YYYY 9 Birth	place (State or
Funeral Director	c	065-22-2929 1 M 2 XF 88	Yrs. Months Days Hours Mir	`	Foreign	
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation			10d. Inside City Limits
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Maryland 28a-f show d at once.	핡	MD NA Baltimo	10f. Zip Code	10g	. Citizen of What Coun	try?
ith the Maryland 23a or 28a-f sho notified at once.	Director	2 North Smallwood Street Apt3	17 21223	ט	.S.A	
5, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene, ten 27 is marked other than "natural", or items 23a or 28a-f she transmatic event, the Medical Examiner must be notified at once	ᇒᅵ	11. Marital Status 1 Never Married 2 Married Armed Forces?	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,
fter de		1 Yes 2 X No 3 X Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify:Blac	k
hours a	g p		cedent's Usual Occupation (Give kind of ing most of working life. DO NOT use re		6b. Kind of Business/Ir Five And	ndustry
6 72 h an "n ical E		Elementary/Secondary (0-12) College (1-4 or 5+)			Departme:	
withii siene.	Completed	12th Grade NA Sal	es Representati	LVE le (First, Middle, Ma	-	
21215-0036 uld be filed within 7 Mental Hygiena marked other than event, the Medica	Be	James Russell	Mary	Doul1	iden damane)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "njury or other tranmatic event, the Medical injury or other tranmatic.			Mailing Address (Street and Number or	Rural Route Numb	er, City or Town, State,	Zip Code)
MD and 2 sho alth and m 27 is			407 Swancreek D	r.Houst	on TX 770	95
re, land freal	Ī		Disposition (Name of cemetery, or other place)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I ar Department of Hec Important: If Ite injury or other tr			mount Cem. 1/	31/08	Baltimor	e,MD
Balti permit. Departm Importa	Ī	21. Signature of Funeral Service Licensee	22. Name and Address of Facility			
	j,	23a. Part I. Enter the disease, or complications that caused the death. Do not e	1101 E.North A			21202 Approximate Interval
Physician Modical		failure. List only one cause on each line.		or respiratory arres	it, shock, of fleat	Between Onset and Death
caminer	- [Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascula Due to (or as a consequence of):	Disease			200
		Sequentially list conditions, b				
	된	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Clicages or injury that initiated				
760, icate be executed physician and ithe burial - transit		events resulting in death) Last Due to (or as a consequence of): d.				
60, ate be executed obysician and re burial - trans	Medical	UNPENDED AMENDED				
760, Teate by g physic the bun		IF FEMALE: 23b. Was decedent pregnant in the	7 5 4 4 4 4 3 7 5 atomic means		23d. Date of delivery	
ox 68 eath certif	cian	past 12 months? Live birth Pregnant at time of death 5	Fetal death 3 Ectopic pregr Other (Specify)	nancy	Month [oay Year
Box 687 le death certific the attending red for use as the	Physician/	1 Yes 2 No 9 Unknown g Unknown				
res that the d signed by the signed by the		Part II. Other significant conditions contributing to death but not resulting it	the underlying cause given in Part I.		acco use contribute to	
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cords law requi	blet			24a. Was ar autops	y prior to o	topsy findings available completion of cause of
Reco The law icate has	Completed by			perform 1 Yes 2		es 2 No
Vital Rec ysician; The his certificate director, page	Be C	25. Was case referred to medical examiner? Hospital: 1 Inpution: 2 FB/Out	26.Place of Death (Chec			
of Viting Physic	၉၂	1 Yes 2 No Inpatient 2 ER/Out	natient 3 DOA Other Nurs		Residence 6 Other	: Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death. The Director: After this certificate has been sided in by the funeral director, page 2 should be an end in by the funeral director, page 2 should be a second to be a second t	ä	27. Manner of Death 1 ✓ Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Tit	1 Yes 2 No	20d. Describe no	ow injury occurred	
isio Atten r deat rector by the	igat 	2 Accident Investigation 28e. Place of Injury - At home, farm	n, street, factory, office building, etc.	28f. Location (St	reet and Number or Ru	iral Route Number, City
Div ital or ital or al Div	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Sta	ate)	
8 - 3 8		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or inv	occurred at the time, date and place, are	nd due to the cause	(s) and manner as stat	ed.
To the To the comp	Medical	2 Medical Examiner: On the pays of examination and/or invariant and manner stated. 29b. Signature and title of certifier	29c. License number	. at the time, date a	29d. Date signed (Mo	
	2		O.C.M.E.		January 25, 200	
		20 New and address of account the completed course of death (from 22a)	3.3.M.E.			
3		 Name and address of person who completed cause of death (Item 23a) David Fowler M.D. Chief Medical Examiner 111 Pe 	nn Street, Baltimore, MD 2120	1		
Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	head 1			
Registi		FEB 0 1 2008				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Clouser 1. . February 2008 02:05 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner 519 Newfield Road Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 21 19 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 216-18-7182 83 1924 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☑ No must be notified Director Maryland Anne Arundel Glen Burnie 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code ò 519 Newfield Road 21061 USA 23a Funeral items 2 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married P Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: White 3 ☑ Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Department Stores Department of Health and Mental Hygic important: If Item 27 is marked other 1 any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Thielbahr Annie В. Nagel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane L. Koblinsky (daughter) 519 Newfield Road, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. Date 05 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Baltimore, Maryland Cedar Hill Cemetery 21. Signature, Funeral ervice Licens 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complication it at aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart sliture. List only one care each line. Immediate Cause (Final disease or condition resulting in death) Physician 4200 to (or as a consequence of) /Medical 8 72001 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No Be (25. Was case referred to predical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 TIN6 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation To the Funeral Director: A

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -V-CYRIAC.M-B 17CHIR 8021

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 11 11 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 27, 2008 J<u>anuary</u> Margaret A. Carl /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Heartlands Assisted Living Ellicott City Howard If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** 1□M 2₹F 102 Nov. 19,1905 Maryland Director 722-12-3913 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 No Maryland | Howard Ellicott City Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or pe USA r than "natural", or Items 23a the Medical Examiner must b 3004 N. Ridge Road 21043 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White If Yes, Give Year or Dates: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 Elementary/Secondary (0-12) College (1-4or 5+) Railroad Secretary 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any injury or other traumatic event, <u>th</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ridgely L. Griffith Margaret Stumpner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 201 Rolling Brook Way; Catonsville, MD 21228 Joan E. Cass Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)

21. Signature □ Fineral Service □ ensee Crestlawn Mem. Gardens 2-1-2008 Marriottsville, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 101290 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Demento /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Dav Year in the past 12 months? 5 Other (specify) 4 □ Pregnant at time of death ☐Yes 2☐No ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 22000 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be (Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After (Month, Day Year) Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hin 24 hours after death. the Funeral Director; A npletely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 24 hor To the Fune completely f 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

FEB 0

Cenday 32 Registrar's Signature 2008

NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1120 N. Rolling RD Ballo MO 21278

Drorin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 0.00

02587 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 8:12 P M 29. 2008 January <u>Kathleen Mary Collins</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Frederick Villa Nursing Home Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) Sept. 16, 1923 Maryland 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🗓 F 84 Director 216-14-8700 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d, Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Catonvsille 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 103 S. Hilltop Road 21228 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 7 is marked other traumatic event, tl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Fluskey Edward T. McNaney 2 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. James Patrick Collins, Jr. 103 S. Hilltop Road; Catonsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Marriottsville, MD Crest Lawn Mem Garden 2/2/2008 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Fundral Service 1101290 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition ATheroscleronic Cardio Vascular Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 ☐Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 2 No Hospital: Other: 1 Inpatient မှ 1 ☐ Yes 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) s after death.

I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Funeral 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hos within 24 ho To the Functional 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Attending MO 20303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIGN ROLLINGRO STE 205 Catums will RNANDE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 30, 2008 Physician 5:25 P.M ANNA VIRGINIA CHENOWITH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMORE STELLA MARIS HOSPICE TIMONIUM Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🔀 F 86 10/6/1921 MARYLAND Director 214-20-0382 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director PARKVILLE MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ", or items 23a or 2 caminer must be n 9215 SMITH AVENUE 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ 3 XWidowed 4 ☐ Divorced WHITE Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **HOMEMAKER** OWN HOME 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked EDNA HAGEDORN PETER CASPER HEIN 1 and 2 should ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LINDA WILSON/DAUGHTER 15 NORTHAMPTON ROAD TIMONIUM, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State DRUID RIDGE CEMETERY 2/4/2008 PIKESVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) xpertension **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or Joryang Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospital: 1 🔲 Yes 2No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 29a. Certifier 1 🐆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAhmood 32. Registrar's Signature

300

Baltimore,

1

CNO EL

Box 68760.

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Records,

Vital

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Division

2300

29c. License number

43725

Dulaney Villey RD

29d. Date signed (Month, Day, Year)

Timo rium, mo. 21093

1/3/108

08-00606 James Cook Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 02589

		I- For State Registrar	Certifica			ı work		g. No.	00 0230
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Medical Exami		James Cook 4a. Facility Name (if not institution, give street and number)		4b.	City, Town, or I	Location o	January 22	2, 2008 4c. County of De	
		Prince George's Hospital Center			heverly			Prince Geo	
Funeral		5. Social Security Number 6. Sex 7. Age (In y	rs. last birth		f Under 1 Year Months Days		24Hrs. 8. Date of Bir	h(MM/DD/YYYY) 9.	Birthplace (State or reign
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any	H	Usual Residence of Decedent 10a. State 10b. County 10c. 0	City, Town o	r Location					10d. Inside City Limits
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Aarylau 28a-f s	Director	10e. Street and Number		10	of. Zip Code		1	0g. Citizen of What 0	Country?
with the Maryland us 23a or 28a-f sho		435 Pine Valley Rd.			30126			USA	
ath wit	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	n U.S.				in? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Ar White, et	merican Indian, Black, c.
15-0036 filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once		3 Widowed 4 Divorced If Yes, Give Year	lo	1 Ye	s 2 X No	specify:		Specify:	Black
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	d by	15. Decedent's Education (Specify only highest grade completed			Jsual Occupati		rind of work done	16b. Kind of Busine	ess/Industry
36 in 72 h nan "n lical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			of working me.	DONOT	use remed)		
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21215-0036 vald be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	John Cook				Addie	Johnson		
D 21 should and Me	٤	19a. Informant's Name/Relationship (Type, Print) Lisa M. Cook - wife	187	_			ber or Rural Route Nur lableton, Geor	-	itate, Zip Code)
imore, MD 2 Pages 1 and 2 shou ment of Health and N lant: If item 27 is n or other traumatic		20a. Method of Disposition 2	0b. Place of	f Disposition	n (Name of cer	netery,	Date	20c. Location - Cit	y or Town, State
Baltimore, permit Pages I an Department of Her Important: If ite		1 Burial 2 X Cremation 3 Removal from State	cremato Metropo	ry or other litan	^{place)} Cremator	у	Jan. 27,2008	Alexandria,	Virginia
Baltimord permit Pages I Department of I Important: If	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		22. Nam	e and Address k Funera	of Facility	INC		
		MEGK MO1234		7601	Sandy S	pring	Rd., Laurel,		707 Approximate Interval
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tal Rection: The certificate ector, page	ပိ	25. Was case referred to medical			26.Place	of Death	1 Yes (Check only one)	2 No 1	Yes 2 No
Vita hysicia this ce	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	₽ ER/Ou	itpatient 3	DOA _	Other _	Nursing Home 5	Residence 6	Other:
n of Vi ling Physi After this funeral dir		27. Manner of Death 1 Natural 5 Deating 28a. Date of Injury (Month, Day, Year)		ime of Inju		ry at Work		how injury occurred	
IVISIOD or Atteno after death Director:	cati	2 X Accident Pending Investigation June 8, 2007 28e. Place of Injury -		L4 pm		Yes 2 X	pedebers	an hit by vo	ehicle(s) or Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director: stely filled in by the i	Certification:	3 Suicide 6 Could not be determined (Specify) Roadwa		iiii, 34 66t, i	actory, office E	Januariy, Co	or Town.		
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinating the control of	wledge, dea on and/or ir	th occurred	at the time, da	ate and pla	ace, and due to the cau	se(s) and manner as	stated.
To the within To the comple	Medical	29b. Signature and title of certifier			29c. Licens				(Month, Day, Year)
		and			O.C.	M.E.		January 24, 2	2008
Ø		30. Name and address of person who completed cause of death (Ana Rubio MD. Assistant Medical Examiner		Penn Str	eet, Baltimo	ore, MD	21201		
	ate	31. Date filed (Month, Day, Year) 22. Registrar's Sig		P 20		<u> </u>			
Regist		FEB 0 1 2008	- fresh	Carlo Carlo					
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State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	le of Marylan		tificate of I			leg. No. 2 () () {	3 02590
E	Physici	an	1. Decedent's Name (First, Middle, Last)					Date of Dea Month	th Day Year	3. Time of Death
	/Medic		Luvisie Craig					January 1		12:45 A M
	Examin	er	4a. Facility Name (If not institution, give street	and number)			Location of Death		4c. County of Dea	
			Laurel regional Hospital 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	Laure1	If Under 24 Hrs.	8. Date of Birth	Prince Ge	orges rthplace (State or Foreign
k	Funeral Director		UNK 1 □ M 2		Yrs.	Months Days	Hours Min.	July 18,	, Year) C	ountry) issippi
	land ow		10a. State 10b. County	10c. Cit	ty, Town or Loc	ation				10d. Inside City Limits
	Mary I-f sh	tor	California Los Angeles	Can	oga Park	<				1 ∐Yes 2 X No
	h the r 28a r noti	Director	10e. Street and Number			10f. Zip Code		1	l0g. Citizen of What C	ountry?
	th wit 23a c 1st be	al D	22319 Runnymede Street			91303			USA	
	r dea ems er mu	Funeral	11. Marital Status 12. Wa	s Decedent Ever in Uned Forces?	.S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spanic Arigin)	pecify Yes or No-	14. Race - Am Black, Wh	
36	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by Fı	1 Never Married 2 Married 1]Yes 2 1 ⊡No ′es, Give			Specify:			Black
21215-0036	houn tural	ed b	15. Decedent's Education	ar or Dates:	16a, Deced	ent's Usual Occup	ation		16b. Kind of Business	s/Industry
15	in 72 n "na Medic	plet	(Specify only highest grade comp		(Give F	kind of work done of NOT use retired	during most of wor.	king		,
212	d with giene er tha the l	Completed	Elementary/Secondary (U-12)	llege (1-4or 5+) 2	Seamstr	ess			Clothing	
b	al Hy l othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surname)	
yla	ould to Ment arked atic e	P	Joseph Davis				Sarah Ma			
Maryland	12 sh h and 7 is m rraum		19a. Informant's Name/Relationship (Type. Pr.	nt)					r, City or Town, State,	
e,	1 and Healt em 2 ther		Marvin H. Craig- son 20a. Method of Disposition	20b. F				oga Park,	California 9 20c. Location - City o	
nor	ages ent of t: If it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	ii ii oiii State		sition (Name of patory or other place n Crematory		16, 2008	Alexandria,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at onee.		21. Signature of Funeral Service Licensee		-	Name and Addres		10, 2000	Arexandi ia,	VIIgiliia
ñ	Dep Imp any onc		Man M	01234			Home, INC		laryland 2070	7
	E I E		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the deat	h. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Anoxia Encepi						Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a conseq						
	Examiner	_	Sequentially list conditions, b.	Multi Organ						
, 0	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	Sepsis	talender otto					
Np	xecur and al-trar	Examiner	triat initiated events	Oue to (or as a conseq	uence of):					
(8760,4	tificate be executed g physician and as the burial-transit	edical	d							
9	rtificat ng phy as th		IC CCAMIC.			,				
ã	leath cert attendin	an/N	23b. Was decedent pregnant	es, outcome pf pregna Live birth 2 ☐ Feta		Ectopic pregnancy	,		23d. Date of do	
P.O. Box	the at	sici		Pregnant at time of c Unknown		Other (specify)			Month	Day Year
<u>С</u>	that the	by Physician/M	Part II. Other significant conditions contributi	ng to death but not res	ulting in the un	derlvina cause aiv	en in Part I.	23e, Did to	bacco use contribute	to the cause of death?
ds,	signe d be	d by	•	•		,,,,,				Probably 4 Unknown
CO	w req been shoul	Completed						24a. Was a	an 24b. Were a	autopsy findings available
Be	he lar e has age 2	dmc						autop	sy prior to med? death?	completion of cause of
<u>ra</u>	an: T tificat tor, pa	Be Co	25. Was case referred to medical				26. Place of Dea	1 Yes th (Check only or	* 	s 2□No
>	iysici iis cer direct	To B	examiner? 1 Yes 2 No Hospita	l: 1 Inpatient 2 □]ER/Outpatient	3 DOA Oth	or:		ence 6 □Other (Sp	ecify)
0 _	ng Pt fter th neral	.ic	27. Manner of Death 28a 1 Natural 5 Pending	. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe h	ow injury occurred	·
Sio	tendil eath. tor: A the fu	catic	2 Accident investigation				Yes 2 □ No			
Division or Vital Records,	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Certification:	4 Homicide determined	 Place of injury - At he building, etc. (Special 	ome, farm, stre fy)	et, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	Hospital 24 hours a Funeral I		29a. Certifier 1/2 Certifying Physician	To the best of my kno	owledge, death	occurred at the tir	me, date and place	, and due to the	cause(s) and manner	as stated.
	e Hos 124 h re Fur	Medical	(Check only 2 Medical Examiner: O							
	To the l within 2. To the I complet	Me	29b. Signature and title of Contifier	/		29c. Licens	e number	2	29d. Date signed (Mor	nth, Day, Year)
			1111000	10en	_	D64874			January 14,	2008
	ø		30 Name and a dress of person who complete				C+ 000	0.1	M 7 - 1 01	0.6.6
			Shahab Bavani, MD	₹ 10724 Litt		ent Parkway	, Ste 200,	columbia,	Maryland 21	U44
	Sta Registr		FER 0 1 2008	The second of th	and the second	S. Carlot				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day E. **Physician** JÄNUARY 2008 09:05M Thelma M. Cole /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🗙 F Months 236-48-6520 May 22, 1934 Director 73 Maryland Usual Residence of Decedent the Maryland 10a. State r 28a-f show notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "naturar", or items 23a or ury or other traumatic event, the Medical Examiner must be r 21204 509 E. Joppa Road USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3X Widowed 4 □ Divorced Year or Dates: 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 0 bus driver balto county schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Lee Woods Anna Bessie Alexander ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Cole/son 4151 Madonna Road Jarrettsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If Ite
any Injury or ot. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Ronald S. Wade, State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 23a. Pant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner ABDOMINAL WOUND INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending physic 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been sig , page 2 should b 2[**X**No 1 ☐ Yes 3 Probably 4 Unknown Completed RESPIRATORY DISTRESS DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform res 2 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ို 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 ☐ Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No spltal or Attendi nours after death. neral Director: A / filled in by the fu 2 ☐ Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide To the Hospital or within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 3 D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND POH TM D M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 1 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 02592 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 26, 18:23 JANUARY 2008 MARY LOUISE CUTHBERT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 S Yrs 1935 North Carolina Director Jan. 8, 219-30-1265 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State in then "netural", or itema 23a or 28a-f show 1 Yes 2 No Director Aberdeen Maryland Harford 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21001 USA 320 Northeast Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Maryland Be permit. Pages 1 and 2 should be Department of Heelth and Mental important: if Item 27 is marked any injury or other traumatic events. Susan Watson Mary Manning 2 Jim (nmn) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1011 Bear Corbitt Road, Bear, DE 19701 Deborah Williams / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cokesbury U.M.C. Cem. 1-30-08 Abingdon, Maryland 22 Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Juneral Service Lice 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 104 /Medical Due to (or as a consequence of): Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events physicien and s the burial-transit OND MANY Due to (or as a consequence of) resulting in death) Last **68760**A Physician/Medical as attending i Box, 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the a should be detached 9 Unknown O 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 Tes 2 No 3 ☐ Probabiy 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes t irector, page 2 s autopsy 1 Yes 2□ No 1 Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 ER/Outpatient Certification: To 2 No 1 Inpatient 3□ DOA ð After thi 27. Marrier of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of **Division** Attending Injury 5 Pending after death.
I Director: Af 1 □ Yes 2 □ No investigation 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tith of certifier 30. Name and address of person who comple cause of death (Item 23a) (Type, Print) 9 MP evolll 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 Registrar

A A TN CA D E MA GEST Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 28. 2008 JANUARY ROBERT (NMN) DAMSGAARD JR. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE GILCHRIST @ GBMC TOWSON Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 5. Social Security Number Months Davs Hours 1⊠M 2□F Aug. 1, 1946 Maryland 215-46-7531 61 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Harford Forest Hill 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 713 Walters Mill Road 21050 USA 12. Was Decedent Ever in U.S. Armed Forces? 1♥JYes 2□No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 27 Married 1 ☐ Yes 2 ☐ No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Pharmaceutical Company Pharmaceutical Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Damsgaard Sr. Annalise (nmn) Robert (nmn) Aardrup 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 713 Walters Mill Road, Forest Hill, MD 21050 of Disposition (Name of Date 20c. Location - City or Town, State Ann M. Damsgaard / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Hilltop Service Corp 2-4-08 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one viuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rostare cance Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 9☐ Unknown 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 110 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2/1/1/2 26. Place of Death (Check only one,

Physician /Medical Examiner burial-trar Box 68760. physician pe the as use

Physician

/Medical

Examiner

Director

Funeral

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Director

Show r 28a-f show notified at

"natural", or Items 23a or

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. Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, the

Department of Health Important: If item 27 any Injury or other to once.

with the Maryland

filed within 72 hours after death

Maryland 21215-0036

Baltimore,

P.O.

Division or Vital Records,

or Attending

Examiner Physician/Medical attending for the a signed by to d be detach Completed page 2 should certificate has Be To After this funeral

Certification: hours after death. filled in by within 24 hours a

State Registrar

Medical

29a. Certifier

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 ☑ No 6 Other (Specify) WJ. DCL 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of D ath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide

and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N. Charles ST TONSON MO 21204

58303

J. CHANGES filed (Month, Day, Year) FEB 0 1 2008

	For State Registrar		State of M	laryland		artment of I rtificate of		d Ment		ne No. 2008	02595
an cal	1. Decedent's Nam	ne (First, Middle, I e Gail	·						ate of Death	29,2008 ^{ar}	3. Time of Death 7:05 A M
er	Upper (Chesapea	ke Medical	Cente		4b. City, Town, Bel	Air			4c. County of Dea	<u>a</u>
	5. Social Security N 217–58–4 Usual Residence o	1415	. Sex 7. A	ige (In yrs. Ia	a <i>st birtnaay)</i> Yrs.	Months Days		Aim (A	ate of Birth Month, Day, Ye	200	thplace (State or Foreign ountry) th Carolina
r	10a. State	10b. County	mfod	10c. City	, Town or Lo						10d. Inside City Limits 1 ☐ Yes 3/17/No
Funeral Director	MD 10e. Street and Nu 1019 Hea	mber	arford			Street 10f. Zip Code 21	154		10g.	Citizen of What Co	
by	11. Marital Status	ried 2□ Married	12. Was Deceden Armed Forces 1	i? ≹ No		Was Decedent of If Yes, specify Cult	Hispanic Origin's pan, Mexican, P	? (Specify Y uerto Rican	es or No- , etc.)	14. Race - Ame Black, Whit	te, etc.
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	19a. Informant's N Martha De	ems-sis	,		1019	Heaps Ro			ryland		
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			For State Registrar	State of Ma	ıryland		artment of H rtificate of I		Mental Hy	giene Reg. No.	2008	02596
r	Dharia		Decedent's Name (First, Middle, Las	,					2. Date of De	eath _	Vear	3. Time of Death
1	Physici /Medic		Hattie	Drakef	ord		1-		Janua			11:00 A M
	Examin	er	4a. Facility Name (If not institution, give	ot institution, give street and number) Oaks Nursing Home 4b. City, Town, or Location of Death Clinton							County of Deat	
47	Funeral		5. Social Security Number 6. Se	ex 7. Age		ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9 Birt	hplace (State or Foreign
Ŀ	Director		239-34-3001	□M 2M/F	84	Yrs.	Months Days	Hours Min.	(Month, Da 3-28	192	3 Nor	th Carolina
	/land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
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	with the a or 28 be no	Directo	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Co	puntry?
	ns 238	Funeral	6711 Coolridge Rd	12. Was Decedent E	ver in U.S	S. 13.	20748 Was Decedent of H	ispanic Origin? (Sr	pecify Yes or No	U.S	A. 14. Race - Ame	rican Indian,
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2☐ Married 3 1 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give X Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	in, Mexican, Puerto Specify:	Rican, etc.)		Black, White	e, etc.
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	al or Att s after de al Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju building, etc	ry - At hor . <i>(Specify,</i>	ne, farm, str	reet, factory, office		28f. Location (City or To	Street and wn, State,	d Number or Ru)	ural Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Medical (29a. Certifier (Check only one)	vsician: To the best of iner: On the basis of and manner star	examinati	vledge, deat on and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occu	, and due to the rred at the time	cause(s) date and	and manner as I place, and due	s stated. e to the cause(s)
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DHMH 17 Rev 1/2001

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	Physicia		James Durham Jr						Month January	18, 2	.008	3:20 PM M
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, or L	ocation of Death			nty of Death	1
			Charlotte Hall Veterans Home Charlotte Hall							St.	Mary'	S
- N	Funeral		5. Social Security Number		e (In yrs. las	- 1	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birth	nplace (State or Foreign untry)
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93	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural" or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	143-4	6 1	□Yes 2∏No	Specify:		Spei	oify: bl	ack
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a)	ss 1 and 2 should of Health and Men Item 27 Is marke other traumatic		20a. Method of Disposition	Train, spouse	20b. Plac		sition (Name of natory or other place		Date	20c. Locatio		
altimore,	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation		cen	netery, cren	natory or other place)			,	
Ħ	artme artme ortan injur		4 ☑ Donation 5 ☐ Other (Spo	//		22	. Name and Address	of Facility				0
Ba	permit. Pages Department of Important: if it any injury or o	J. J	21. Sunature Funeral Service Ronal 4	. Wade, Dir	ector		ate Anato Itimore,			Balti	more	Street
			23a. Part . Enter the disease, or o shock, or heart failure. List o	omplications that caused	the death.	Do not ente	er the mode of dying	, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician	i i	Immediate use (Final disease or condition	iny one sauge on sauring	20.0	6		DEME				Onset and Death
	/Medical		resulting in death)	Due to (or as	a conseque	nce of):	e la		1111			
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0-	D ##	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque	nce of):					-	
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×	death certifi attending	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d.	Date of del	ivery
.O. Box	d for 1	by Physician/M	in the past 12 months?	1 ☐Live birth 4 ☐Pregnant at			Ectopic pregnancy Other (specify)				Month	Day Year
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ري ص	w requires that s been signed b should be deta	y P	Part II. Other significant condition	s contributing to death b	\cap	-	, ,	n in Part I.	23e. Did to	bacco use c	ontribute to	the cause of death?
ğ	equire en sig		HURRIS	$n \leq 100$	DIA	BETT	8 MELL	IMS	1 🗆 1	res 2 □ No	3	obably 4 Unknown
Records,	has be	Completed	HYPOTE	14RUIDIS	7.				24a. Was a		b. Were au	itopsy findings available
Ÿ	The ate his page	mo.							perfo	rmed? 2 X No	death? 1 ∐ Yes	2 □ No
<u> </u>	hysician: The la nis certificate ha I director, page 2	Be (25. Was case referred to medical examiner?					26. Place of Deat	th (Check only o	ne)		
<u>></u>	this o	L _O	1 ☐ Yes 2/K2 No	Hospital: 1 Inpatie			t 3 DOA Other	42 Nursing Ho	ome 5 Resid			cify)
Division or Vital	ding Phy h. After thi funeral o		27. Manner of Death 1 Salatural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry 2 y Year) 2	28b. Time of Injury	Work		28d. Describe h	ow injury oc	curred	
<u>s</u>	Attender death rector: by the f	icat	2 Accident investiga 3 Suicide 6 Could no	ot be 380 Place of ini	un/ - At hom	e farm str	M 1 ☐ Y eet, factory, office	es 2 □No	28f Location (9	Street and No.	ımber or Bı	ural Route Number,
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	Hospital or Atteno 14 hours after death Funeral Director: tely filled in by the			Physician: To the best								
	To the Hospital or Attending Physician: The law requires that the death certif with 24 hours attendes the Two and the Funeral Directors After this certificate has been signed by the attending to the Funeral Directors. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	one)	xaminer: On the basis o and manner st		JII and/or in						
	With To 1	Σ	29b. Signature and title of certifier				29c. License	number				th, Day, Year)
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			30. Name and address of person w	•		,	Print) tte Hall 1	Votorana	Home			
	Sta	te	31. Date filed (Month, Day, Year)	SPHANI, M 32. Registr	ar's Signatu	E TOTT TO	CCC HOTT	ACCETATIO	TOUR			
	Registr		FEB 0 1 2008	32. Registr	A A	nessee s						

			For State Registrar		epartment of Health ar Certificate of Death		giene Reg. No. 2008	02598
0.1	8 3 1		Decedent's Name (First, Middle, Last)			2. Date of Dea	ath	3. Time of Death
	Physici /Medio		Donald Walt	con	Dickson	Januar	V 29 2008	7 1:48 am
	Examir	er	4a. Facility Name (If not institution, give stree	et and number) Center	4b. City, Town, or Location of La P	Death lata	4c. County of Dear	les
3	Funeral Director		5. Social Security Number 6. Sex 276–22–5169	2□ F 7. Age (In yrs. last birtho	Months Days Hours	Hrs. 8. Date of Birtl Min. (Month, Day Aug 22	9. Bird 4, 1927 On	thplace (State or Foreign puntry)
	w w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location			10d, Inside City Limits
	f shore	ō			Fort Washington			1 ☐ Yes 2 ☑ No
	the h	rect	Maryland Prince Geor	ige s	10f. Zip Code		10g. Citizen of What Co	ountry?
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	12308 Dendron Place	9	20744		U.S.A.	
1	ems :	ner		Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican,	n? (Specify Yes or No- Puerto Bican, etc.)	14. Race - Ame Black, Whit	
920	172 hours after death with the Marylar "natural", or items 23a or 28a-f show edical Examiner must be notified at	by	1 Never Married 2 Married	1 KWes 2 □ No 1946 − If Yes, Give Year or Dates: 1985	1 ☐ Yes 2 ☐ No Specify:	r derio riican, etc.	Specify: Wh	·
2	72 hor	Completed	15. Decedent's Education (Specify only highest grade co	on 16a. D	ecedent's Usual Occupation	of working	16b. Kind of Business	/Industry
121	ithin ne. han "	mple		College (1-4or 5+)	Give kind of work done during most of fe. DO NOT use retired)	or working		
12	filed w Hygie ther th		12th 17. Father's Name (First, Middle, Last)	8+ C	OL. USAF Ret.	s Name (First, Middle,	U.S. Gover	nment
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical I once.	To Be		ickson			eber	
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type.		lailing Address (Street and Number			
	and 2 ealth a n 27 i		Nancy Dickson (Wife		308 Dendron Plac	e Ft. Wash		
Baltimore,	ges 1 t of Hu if Iter or oth	111	20a. Method of Disposition 11☑ Burial 2 ☐ Cremation 3 ☐ Remo	20b. Place of D cemetery,	isposition (Name of crematory or other place)	archite 21,	20c. Location - City or	
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Bal	permi Depar Impo any Ir once	1 30	21. Signature uner Win Licensee	MO1464	22. Name and Address of Facility 6633 01d Alexan		ral Home, I Road Clint	
la l	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one commendate Cause (Final disease or condition	ause on each line.				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Card Due to (or as a consequence of) Bilater	0 / 2		(maca)	week.
					PAIM CONTRACT	VELL MARKET		
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8760,	cate be executed physician and the burial-transit	dical	triat mitiated events	Due to (or as a consequence of)	D	NEU MONICA	(/~K³ //)	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🛭 🗎 S Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician JANUARY 3:40 P M RAYMOND (MMN) DAVIS SR. 24, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE TIMONIUM HARFORD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 XM 2 ☐ F Director 120-34-6617 29 New York 61 1946 Jan: Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d, Inside City Limits 28a-f sh notified 1 □Yes 2 No Director Maryland | Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 1435 St, Christopher Ct. USA 21040 Funeral ural", or Items 2 I Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: <u>م</u> 3 ☐ Widowed 4 ☑ Divorced Black 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Can Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Robert Davis Mattie Lee King ၀ Health and New 27 is ma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lovett Davis / Son 25 Perry Oak Place, Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 1-28-08

22. Name and Address of Facility
McComas Funeral Home, P.A. Towson, Maryland 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Vital Records, P.O. Box 68760, Cy burial-tra Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has performed 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence SQOther (Specify) Hospice 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year)

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RAYMOND

DAVIS,

Registrar
DHMH 17 Rev 1/2001

2300 DULANEY VALLEY ROAD

3034 E

TIMONIUM

21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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2008

TARIO MAHMOOD,

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31. Date filed (Month, Day, Year)

			for State	of Maryland / D			lental Hy	giene	00000
		_	■ Registrar		Certificate of	Death	2. Date of Dea	Reg. No Z U U	3 02600
	Physici	an	1. Decedent's Name (First, Middle, Last) Ellarose Elizabeth	, Emmol			Month	Day Yea	6.4
	/Medic		4a. Facility Name (If not institution, give street and		4b City Town o	r Location of Death	January	7 30 , 2008 4c. County of Di	1:26 P
	Examin	ier	2611 Old Joppa Road	(Hamber)				,	
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	Jop oday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		rford Birthplace (State or Foreign Country)
	Director		212-50-7181 1□ M 2 🔀	F 90 Y	rs. Months Days	Hours Min.	(Month, Day	y, Year) 5, 1917 Ma	
	D.		Usual Residence of Decedent				Mar. I	J, 1911 14	
	rylan how		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	e Ma Sa-f s tiffied	cto	Maryland Harford	Joppa					1 □Yes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
	ath w		2611 Old Joppa Road		21085			USA	
	within 72 hours after death with the Maryland piene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	Arme	Decedent Ever in U.S. d Forces?	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 14. Race - Al Black, W	merican Indian, hite, etc.
30	s afti	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Y If Yes 3 ☑ Widowed 4 ☐ Divorced Year	es 2 No , Give or Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify:	
2-003p	hour Itural	Pa Pa	15. Decedent's Education		Decedent's Usual Occup	ation		16b. Kind of Busine	White
Ċ	in 72 " na" n	Completed	(Specify only highest grade complet	ed)	Give kind of work done of life. DO NOT use retired	during most of work	ing	TOD. TAING OF ENGINEE	30/11/403/19
7	within jiene.	E O	Elementary/Secondary (0-12) Colleç	ge (1-4or 5+) HOr	nemaker			Own Home	2
0	e fillec Il Hyg othe	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Surname)	
<u>a</u>	uld be Aental rked c ric eve	To E	Jacob H. Hohl			Anna (N	MN) Bra	ındt	
ar	s 1 and 2 should f Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type. Print)		Mailing Address (Street				, 1/
Σ,	and and n 27 n 27 ier tr		Kim A. Williams / Gran					le, MD 210	087
ore			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fr	20b. Place of I cemetery	Disposition (Name of crematory or other place	ce) 2-2-	Date -08	20c. Location - City	or Town, State
altimo	Pag tment tant: Jury		4 ☐ Donation 5 ☐ Other (Specify)	/ Frankl:	<u>inville Pre</u>		1	Bradshaw,	Maryland
ga	permit. Page Department of Important: If any Injury or once.		21. Signature of Fureral Service Licensee		22. Name and Addre	ss of Facility uneral Ho	me, P.A	١.	
	σ⊓ = a α		Charleng f		1317 Coke	sbury Roa	d, Abin	gdon, Mary	land 21009
			23a. Fart1. Enter the disease, or com and till sit shock, or heart failure. List only lie "use	each line.	of enter the mode of dyin	ig, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Kenal ta	iluc				2 minths
	Examiner		Due	to (or as a consequence of	ř):				
		P.	Sequentially list conditions, if any leading to immediate	to (or as a consequence of	i):				yeur
2	insit	Ë	Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated causers)						10
,	executed n and ial-transit	Examiner	triat initiated events	e to (or as a consequence of):				
28/00,	ficate be executed physician and is the burial-transit	edical	d						
	rtifica ng ph as th	Medi	IF FELLUS						
o o	th cer endir r use	an/N	200. Was decedent pregnant	outcome pf pregnancy ve birth 2 Fetal death	3 ☐Ectopic pregnancy	1		23d. Date of	
	e dea	sici	1 Yes No 4 P	regnant at time of death	5 ☐ Other (specify) _			Month	Day Year
י י	at the	Physician/M	9 Li Unknown			. 5	00 Did.		
Š,	w requires that the death certific been signed by the attending p should be detached for use as	by	Part II. Other significant conditions contributing: Propheral Udular e		the underlying cause give	en in Part I.		obacco use contribute Yes 2□ No 3□	to the cause of death? Probably 4 Unknown
ecords	requi	ted	TO THE OWNER OF	N'eares					Probably 4 Officiowii
	e law has b	Completed					24a. Was autop	an 24b. Were prior	autopsy findings available to completion of cause of ?
VIII	cate						1⊟ Yes	rmed? death 25 No 1 ☐ Y	es 2□No
=	siciar certif	Be	25. Was case referred to medical examiner? Hospital:		oatient 3 DOA Oth	26. Place of Deat			
Ö	Physral di	-T	I les 20140	Inpatient 2 ER/Outpate of Injury 28b. Ti	Attent 3 DOA	4 Li Nursing Ho		dence 6 Other (S	pecify)
	ding h. Afte fune	tion			ury Wor	k? Yes 2 □ No		non injury occurred	
VISION	After r deal sctor	fica	3 Suicide 6 Could not be determined 28e. P	lace of injury - At home, farr	n, street, factory, office		28f. Location (S	Street and Number or	Rural Route Number,
5	al or after	Certification:	4 ☐ Homicide determined b	uilding, etc. (Specify)			City or Tou	vn, State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 and 1 and 2 and		29a. Certifier (Check only 2 Medical Examiner: On the	the best of my knowledge,	death occurred at the tir	me, date and place,	and due to the	cause(s) and manner	as stated.
	the H iin 24 the F	Medical	one) and r	nanner stated.					
	with To con	2	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
			1 (1) ha mo		102			1/3110	00
	P		30. Name and address of person who completed of		ype, Print)	PATIL	16 0	ubrise	
	Sta	ite		? Registrar's Signature				WD Z. JOS	
	Pagietr		FER 0 1 2008 La	Rear All	Alamak .				

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			1 - State of I	Maryland / Depa <i>Cei</i>	artment of Hea <i>rtificate of De</i>			ene2 () () 8	02601
b.	Dhysisi	an l	Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Saveria M.		Sisher	J	anuary	28, 2008	11:00P ^M
)	Examin	er	4a. Facility Name (If not institution, give street and numb Glen Burnie Health & Reha		4b. City, Town, or Loc	ation of Death		4c. County of Deat	
-2.3	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year If U		Date of Birth (Month, Day, Y	Anne Arun	nplace (State or Foreign untry)
	Director		215-12-8399 1 M 2 X F	85 Yrs.	Months Days He	ours Min. F	eb.16,	1922	MD MD
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl a-f sho ified a	tor	MD Anne Arundel	Glen E	Burnie				1 ☐Yes 2 X No
	th the or 28a e noti	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	untry?
	ath wi		7355 E. Furnace Branch Ro		21060			U.S.A.	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. The file m 27 is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	X No	Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 No Sp		Yes or No- an, etc.)	14. Race - Ame Black, White Specify: W	
22	"natu	etec	15. Decedent's Education (Specify only highest grade completed)	ı (Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n g most of working	16	6b. Kind of Business/	ndustry
12	withir iene. than he Me	Completed	Elementary/Secondary (0-12) College (1-4	or 5+)	rk Typist			Accounti	nσ
מ	e filed Il Hyg other rent, t	Be C	17. Father's Name (First, Middle, Last)	1		Mother's Name (Fi	rst, Middle, Ma		
<u>Ja</u>	should be ind Mental marked o umatic eve	TOE	Antonio Miceli		M	fary Brig	andi		
/ar	2 sho		19a. Informant's Name/Relationship (Type. Print) Hu: Mr. Martin R. Fisher Sr.	,	ng Address (Street and I				
	1 and Health Sem 27 Sther to		20a. Method of Disposition	7,540	Old Telegra position (Name of matory or other place)	ph Road Date		MD 2107 oc. Location - City or	
JOIL .	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (**Specify**)	ate	matorý or other place) .dge Memoria	Jan 31 1 2008		lkridge,	MD
Baltimore,	permit. Pag Department Important: It any injury o		21. Signature of Liner Service Licensee		2. Name and Address of				
<u> </u>	8 3 E 8		· KTML	S	Services 1 2				
		y 19	23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death. Do not ent h line.	ter the mode of dying, su	uch as cardiac or re	spiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	etabolic Enc	ephalopattu	1			
ı				Ho brouter	we o	(
91		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of):			-		
_	and and I-trans	Examiner	that initiated events C	as a consequence of):	<u>S</u>				
68760	icate be executed physician and s the burial-transit	cal E	U_1	rinary trav	t infection	.			
89	rtificat ng phy as th	Aedical							
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M		h 2 ☐ Fetal death 3 ☐ nt at time of death 5 ☐	□Ectopic pregnancy □ Other <i>(specify)</i>			23d. Date of del Month	very Day Year
	s that ned by e deta	by Ph	Part II. Other significant conditions contributing to deat	th but not resulting in the u	ınderlying cause given in	Part I.	23e. Did toba	cco use contribute to	the cause of death?
ğ	equire en sig ould b						1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Munknown
		Completed					24a. Was an autopsy performe 1 Yes 2 L	prior to	topsy findings available completion of cause of
VITE	tending Physician: The eath. tor: After this certificate hathe funeral director, page.	Be	25. Was case referred to medical examiner? Hospital:		Othori	Place of Death (C			
0	Physer this eral di	. To	27. Manner of Death 28a. Date of		nt 3 DOA 4	4		ce 6 ☐Other (Spe injury occurred	cify)
<u>o</u>	ath. r: After e funera	atior	1 XNatural 5 ☐ Pending (Month, 2 ☐ Accident investigation	Day Year) Injury	M 1 ☐ Yes	2 🗆 No			
Division or	700>	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of building	f injury - At home, farm, sti ,, etc. (Specify)	reet, factory, office	28f.	Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of the	is of examination and/or in					
i	To the within 2 To the complex	Ž	29b. Signature and title of certifier		29c. License nui			d. Date signed (Mont	
)				ysician	D569:	٥,	JA	invary 29	, 2008
			30. Name and address of person who completed cause who was a few ways and was a few was a few ways and was a few ways and was a few was a few ways and was a few was a	of death (Item 23a) (Type,	Print) DS69: Park Drive	Suite 11	Clen	Burnle	ND 21061
2 1	Sta	te	31. Date filed (Month, Day, Year) 32. Fig	gistrar's Signature	Carth &		0.1-71	.,	
	Registr	ar	FEB 0 1 2008	Strang At Ag					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🔒 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 29, 2008 21:50 Faith A. Fahenstock January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford County Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 💢 F 60 218-48-2095 1, 1947 Maryland Director Mav Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No r 28a-f sh notified Harford Co. Maryland Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 1509 Honeysuckle Drive 21014 United States Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite any injury or other traumatic event, the Medical Examine 1 ☐ Yes ZXXIVo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐XNo Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4or 5+) Veterans Affairs 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Esther Hoffman Henry A. Legge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard Fahnestock 1509 Honeysuckle Drive Bel Air, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1/31 2008 1 ☐ Burial 2XICremation 3 ☐ Removal from State Forest Hill, MD. 4 □ Donation 5 □ Other (Specify) Evans Funeral Chapel 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Evans Funeral Chapel & Cremation Services
3 Newport Drive, Forest Hill, MD 21050 23a. Parti. Enter the diseas of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. If to only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 9dag ermia /Medical Due to (or as a consequence of): **Examiner** hdo Cardi Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Q I Inknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. F. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar Larce

Marco

FEB 0

Year

30. Name and address of person

31. Date filed (Month, Day,

death with the Maryland

er Chesapeake Drive.

completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

amora

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g876, 02/01/08dbb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** OUINCY FORD JAWUAKY 20 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES DOCTOR'S COMMUNITY HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours XXM 2□F CALIFORNIA SEP. 1955 Director 559 96 1391 52 15, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show notified at XX Yes 2 No Director CAPITOL HEIGHTS 28a-f MD PRINCE GEORGES 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò other traumatic event, the Medical Examiner must be 20743 UNITED STATES 'natural', or Items 23a 6805 MOUNTAIN LAKE PLACE death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces' XX Yes 2 No If Yes, Give Year or Dates: 1977-83 within 72 hours after 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: BLACK à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien. Important: If Item 27 Is marked other that any Injury or other traumest. 2YRS. MERCHANDISER PEPSI CO. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 0 ROYCE FORD ADA SCOTT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6805 MOUNTAIN LAKE PL. CAPITOL HEIGHTS, MD 20743 HENRIETTA FORD / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Removal from State METROPOLITAN CREMATORY 01/29/08 4 ☐ Donation 5 ☐ Other (Specify) ALEXANDRIA, VA 21. Signature of Funeral Service Licensee 22.Name and Address of Facility
MARSHALL S FUNERAL HOME OF MARYLAND, D.GRA 1523 SUITLAND, MD 20746 4308 SUITLAND ROAD 23a. Parti. Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonitis **Physician** 100 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of). Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9□Unknown 9 Unknown signed by the Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page ; certificate 1 Yes 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 1npatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral director. P 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò the Hospital 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760,

10100

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State

29b. Signature and title of certifier

31. Date filed (Month, Day) Kear)

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DHMH 17 Rev 1/2001

30. Name and Marass of person who completed cause of the hillem 23a) (Type, Print) PINDE 1251NG1BCCIE MD 20)11

CANT 200832. Registrar's Signature 29c. License number

D45660

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 28, 2008 8:50 P M James Edward Freeman, III January 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Charlestown Care Center Catonsville Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 1 X M 2 □ F 92 705-10-8604 June 5, 1915 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 717 Maiden Choice Lane #325 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1941-42 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Retail Stationers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nellie Gordon Hickman James Edward Freeman, Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Pluhar Daughter 818 Lancaster Drive; Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

a or 28a-f show t be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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death with the Maryland

/Medical

burial-trar

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examiner attending physician Physician/Medical signed by t Be Completed by To the Hospital or Attending Physician; within 24 hours are death.

To the Funeral Director: After this certifica Certification: To

(ot) State Registrar

	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State bulaney	Valley	2-1-2008 Tim	nonium, Maryland
	21. Signatur i veral Service Licer	nse:	22. Name and Address of Facil Funeral Home o 1630 Edmondson	Sterling Ash f Catonsville, Avenue: Caton	ton Schwab Witzke Inc. sville, MD 21228
5 ,1	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death. Do not one cause on each line.	ot enter the mode of dying, such a	s cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
	resulting in death)	Due to (or as a consequence of	n:		
ıminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease on injury that initiated events	Due to (or as a consequence of	n):		
edical Exa	resulting in death) Last	Due to (or as a consequence of):		
Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ed by Pł	Part II. Other significant conditions of	contributing to death but not resulting in t	the underlying cause given in Part		co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Complet				24a, Was an autopsy performed	
3e (25. Was case referred to medical examiner?		26. Plac	ce of Death (Check only one)	
0	1 Yes 2 1√10	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	patient 3 DOA Other: 4 N	ursing Home 5 ☐ Residence	e 6 □Other (Specify)
Medical Certification: To	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	n ` ´ ´	ime of 28c. Injury at Work? M 1 ☐ Yes 2 ☐	28d. Describe how it	njury occurred
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		n, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
edical		wisician: To the best of my knowledge, miner On the basis of examination and and manner stated.			
Σ	29b. Signature and title of certifier	/ wh	29c. License number	29d.	Date signed (Month, Day, Year)
	30. Name and drey of person of	pleted of use of death (Hem 23a) (T	ape, Print) ho ice (and Cotons	sil Mari

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** breer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltinure Bend Ct. WINDSOY MIL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Yrs. 8. Date of Birth (Month, Day, 6. Sex **Funeral** 1 □ M 2 🗸 F -*ai4* Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov amplying or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Bend Cour Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1□Yes 2□No Specify. Specify: Black ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Domestic College (1-4or 5+) tone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental F atherine Middleson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 20c. Location - City or Town, State Bernadette Coles Daughter 7 Braided Whip Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State Carrison Forest 15/08 Owings Mills, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Randallstron, M01401 iberty MUD 21133 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Carcinom **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Justo (or as a consequence oi) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as the attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Ýes 2 No To the Hospital or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 2 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred after death. 28c. Injury at Work? Medical Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

State Registrar

2008 FEB 0

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Road Johnny Cake 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHA

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

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Division or Vital Records, P.O. Box 68760,	pital or Attending Physiclan: The law requires that the death certificate be executed urs after death.	eral Director: After this certificate has been signed by the attending physician and
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		For State Registrar	State of h	nai yiaii		rtificate of De		_	g. No _{co o}	0.0	00505
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Physicia /Medic		Dorothy C. Gasqu						January		0 ^{Year}	5:50 P.M
Examin	ner	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Nursing Center				4b. City, Town, or Location of Death Rockville Montgomery					
Funeral	7		6. Sex 7. /	Age (In yrs.		If Under 1 Year If	Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birthp	lace (State or Foreign
Director		216-16-4171	1 ☐ M 2 🔀 F	84	Yrs.	Months Days F	lours Min.	April 11,	1922	Mary.	land
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s 1 an f Heal item 2 other		Dennis W. Gasque 20a. Method of Disposition		1 ~	Place of Dispo	osition (Name of matory or other place)	····		Oc. Location -		
Page nent o ant: If ury or		1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other (<i>Sp</i>		te		morial Park	Feb. 1	, 2008 R	ockvil	1e, M	aryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menlar Hygiene. Important: If fiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	censee	м0089	6 Rc	Name and Address of bert A. Pui 0 W. Montgo	mphrey lomery Av	Funeral I	Home/Rokville	ockvi , MD	11e, Inc. 20850-2805
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ath ce ttendir or use	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1☐Live birth	2 Feta	I death 3[Ectopic pregnancy			1	te of delive	ery Day Year
the de	ysic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5L	Other (specify)					
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equire een sig ould b							 	1 ☐ Ye	s 2 No	3 Prob	pably .4 Unknown
The law rate has be page 2 sh	Completed							24a. Was an autopsy perform	/	prior to cor	psy findings available mpletion of cause of
n: The ficate or, pag		25. Was case referred to medical	<u> </u>					1□ Yes 2	200	death? 1 🗌 Yes	2 No
ysicla is certi directo	To Be	examiner?	Hospital: 1 ☐ Inpa	atient 2 🗆	ER/Outpaties			h <i>(Check only one</i> me 5 ☐ Resider		ner (Specif	
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. Within 24 hours after death. Complete Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical C	29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the be xaminer: On the basis and manner	s of examina	wledge, deat tion and/or in	h occurred at the time, vestigation, in my opini	date and place, ion, death occur	and due to the ca red at the time, da	use(s) and mate and place,	anner as s and due to	tated. the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	(_/			29c. License nu	umber	29	d. Date signe	d (Month,	Day, Year)
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13		30. Name and address of person of Chuanto 21	any 65	-22	Sly	Print) With Crove	Rd, l	5208. K	lockr	ille	141)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 00;05M **Physician** Robert General 24700 My wan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct 2, 1937 9. Birthplace (State or Foreign 7. Age (In vrs. last hirthday) 6 Sex **Funeral** Hours 1 ₹ M 2 □ F North Carolina 577-52-4887 Director 70 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if tem 27 is marked other than "natural", or items 23a or 28a-f show important: if tem 27 is marked other than "natural", or items 23a or 28a-f show y Injury or other traumatic event, the Medical Examiner must be notified at ange. 1 ☐ Yes 2√√ No DCWashington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 58th Street NE #34 20019 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: black SOUTH ROBERT Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) sales automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha Newkirk Robert General Sr ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20030 P.O. Box 30045 Washington, DC Bertha General/sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\Other(Specify) in state 21. Signature of Funeral Service Licensee Ronal S Warte, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Casse (Final disease or condition resulting in death) **Physician** RR INE MUNITE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) physician Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9☐Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an autopsy performed? Yes 25 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) CHOON C 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

24 hours after death. **e Funeral Director:** After this certificaletely filled in by the funeral director, in within 24 hor To the Fune completely fi

Medical

29a. Certifier

31. Date filed (Month, Day, Year)

FEB 0

29b. Signature and title of dediffe

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D0061765

1 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3350 WIKENS AUF # 30+ BACTIMOBE WS

32 Registrar's Signature 2008

State

State of Maryland / Department of Health and Mental Hygiene) [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Frances Solome Gehret January 17, 2008 4:45 AM^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1836 Emily Drive Harford Edgewood If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months. Min Days Hours 1 ☐ M 2 🎖 F 94 Director 162-09-8412 13, 1913 Pennsylvania Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Bhow** rthan "natural", or items 23a or 28a-f aho the Mudical Exacultar must be notified at MD Harford 1 ☐ Yes 2√2 No Director Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 1836 Emily Drive 21040 Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white Š 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Heelth and Mental Hygiene. Itam 27 is marked other than other traumatic avant, the Mark Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 end 2 should be fil tment of Heelth and Mental H tant: if itam 27 is marked off Be John Sundakas Cassie Dzindeleski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Ledford/daughter 1836 Emily Drive Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o important: if any injury or once. injury or 4 X Donation 5 ☐ Other (Specify) 21. Significand Euneral Survivo State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** moman /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physicien and the burial-transit the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month 4 Pregnant at time of death 5 Other (specify) ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Seridence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ၉ this : After this 28a. Oate of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 atural death. 1 Tyes 2 No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 308 Wa Bu 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** Paul William Guercio January 26, 2008 4:44 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center @ GBMC Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ★M 2 ☐ F Director 212-40-6059 Dec. 18, 1942 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes Ž No Directo Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 604 Wendellwood Drive 21014 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Owner Electric Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Salvatore William Guercio Regina A. Archer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Wendellwood Dr., Bel Air, MD 21014
of Disposition (Name of Date 20c. Location - City or Town, State Maxine C. Guercio / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Christian Ch. Cem 1-31-08 Joppa, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 50 W. Broadway, Bel Air, MD 21014 Approximate Interval Between Onset and Death Blastom 4 Immediate Cause (Final disease or condition resulting in death) **Physician** (0 Rap (-/Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical the attending pr 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) s been signed by the should be detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page 2 No 1 ☐ Yes Fo the Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of after death. I Director: After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number · mo 25205 JANUATY27, 2008

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. R. (e.g. G.BM (G.O.) W. Charles St.

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) January 28, 2008 **Physician** Dorothy Lucille Godlewski 4:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Rising Sun Calvert Manor Health Care Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 512-22-2817 Usual Residence of Decedent <u>Kansas</u> Director 81 1926 Dec. the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Colora Maryland Cecil 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with "natural", or items 23a or 76 Curtis Lane 21917 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite ☐Yes 2X No 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welding Manufacturer Purchasing Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alick (nmn) Falconbridge Anna Lee Bishop injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau Shirley L. Reichenbach/Daughter 76 Curtis Lane, Colora, MD 21917 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Park 1-31-08 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Palet Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical equence of): **Examiner** ongwin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and the burial-tran a consequence of) physician Physician/Medical as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 2□ No 24a. Was an 24b. Were autopsy findings available Be Certification: To

Division or Vital Records, P.O. Box 68760,

						autopsy performed?	prior to completion of cause of death? 1 ☐ Yes 2 ₺ No	
	as case referr	ed to medical			26. Place of De	ath (Check only one)		
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11	anner of Death Natural Accident	n 5	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred	
	☐ Suicide ☐ Homicide	6 □ Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,)	
	Certifier (Check only one)		ysician: To the best of my knoniner: On the basis of examinated and manner stated.				and manner as stated. I place, and due to the cause(s)	
20h 5	Signature and	title of certifier		1	29c. License number	29d, Dat	e signed (Manth, Day Year)	

State Registrar

Medical

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person who completed cause of death (Item 23a) (Type, Print)

Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 9008 M SUDDARD INVIARY ZCCS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 45515700 JINC Millersville Anne Arundel Social Security Number Age (In yrs. last birthday If Under 24 Hrs Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 □ xF Director 013-12-4044 86 Oct. 6, 1921 Massachusetts Usual Residence of Decedent r 28a-f show r notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Millersville Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be r 271 West Pasadena Road 21108 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ½No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 es 1 and 2 should be filed w of Health and Mental Hygie f item 27 is marked other ti Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Othello Peabody Davis ۵ Alice Elizabeth Riney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 West Pines Drive, Montgomery, TX 77356

Disposition (Name of Date 20c. Location - City or Town, S William Leonard Goddard Jr son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages ' Department of H Important: If it any injury or o 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Meorial Grdn: 1-26-08 Bel Air, Maryland 21. Signature of Funeral Service Licenses Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician YDARS CNGOSTIVE HCART PAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi and Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 ☐No 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OBSTRUCTIVE 1 ☐ Yes 2 No 3 robably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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. Registrar's Signature

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Funer	al		5. Social Security Number 6.	Sex		e (In yrs. la	st birthday)	If Under 1		If Under 24 Hrs. Hours Min.	8. Date of Bi	rth av. Year	9. Bir	thplace (State or Foreign
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of He refresh			20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3	☐Removal from	n State	20b. Pla	ace of Dispo metery, crea	osition (Nam matory or ot	e of her plac		Date	20c. l	Location - City or	Town, State
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he dea the at		SICI	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pre 9□Unl		time of de	ath 5	Other (spe	ecify) _				WOTH	Day Toal
hat the	i		Part II. Other significant conditions	contributing to	death b	ut not resul	ting in the u	nderlying ca	use giv	en in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
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VILCIAN: Incident of certifical ector, pr	9	ne C	25. Was case referred to medical examiner2							26. Place of Dea				
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On Or VILa ding Physician: n. After this certific funeral director,		o O	27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation		onth, Da	y Year)	28b. Time o Injury	M	Bc. Injur Wor	rk? Yes 2∐No	28d. Describe	now inj	jury occurred	
Attending ar death. rector: Afte by the fune		Tical	3 Suicide 6 Could not	pe 28e. Pla	ce of inj	ury - At hor	ne, farm, sti	reet, factory						ural Route Number,
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To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.		Medical		aminer: On the		f examinati				me, date and place opinion, death occu				
Fo the within Fo the		Me	29b. Signature and title of certifier					290.	. Licens	se number		29d. E	Date signed (Mon	th, Day, Year)
			Dave 38	B	_				03	2279		JAY	nuary2	5,20-4
9			30. Name and address of person who						T17	ATD 35	01017			7
			31. Date filed (Month. Dav. Year)	615 W.	Registr	ar's Signat	ROAD ure		EL.	AIR, MD.	21014			
Regi	Stat istra	-	FEB 0 1 2	008	S. Coco	5 1	ure							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Rea. No. Menth 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Vear 2008 12:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7670 Pine Knob Road Pasadena Anne Arundel 8. Date of Birth (Month, Day, Yea If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) 6. Sex **Funeral** Days Hours Months 1 M 2 F 245-36-6827 79 Yrs Director May 14 1928 NC Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be n 7670 Pine Knob Road 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. ģ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetician Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harlev ပ Rhodes Edith Newman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Rivera (daughter) 7670 Pine Knob Road, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery Glen Burnie, Maryland 21. Signa ure of Funeral Service Lidensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disc shock, or heart failu ease, or co Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 □Unknown 1 TYes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has 3.2. certificate ha autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: ပို 1 ☐ Yes 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner or L inper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

Year)

32. Registrar's Signature

			For State Of Marylar - State Registrar		rtificate of Death		eg. No 2008	02614		
50	Physici		1. Decedent's Name (First, Middle, Last) Alfred William Hogan			2. Date of Death January	3 ⁴ , 2008	3. Time of Death 7:00 A M		
	/Medio Examir		4a. Facility Name (If not institution, give street and number) 6828 Harewood Park Drive	<u> </u>	4b. City, Town, or Location of Death Middle River)	4c. County of Dea Baltimor			
4	Funeral Director	III (5. Social Security Number 213-01-2986 6. Sex 1 ☑ M 2 ☐ F 81		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 07/14/1	- Pi	thplace (State or Foreigr ountry) cyland		
	Maryland -f show iled at	tor		ty, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 🛣 No		
	with the 3a or 28a t be notii	I Direc	10e. Street and Number 6828 Harewood Park Drive		10f. Zip Code 21220		0g. Citizen of What Co	ountry?		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in UArmed Forces? 1 □ XYes 2 □ No	WII	Was Decedent of Hispanic Origin? (S) if Yes, specify Cuban, Mexican, Puerling Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	nite		
2121	l within 7 jiene. r than "r the Med	omple	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done during most of wor DO NOT use retired) CVISOC		Steam Fitt	ting		
Maryland 2	ould be filed Mental Hyg arked othe atic event,	ě	17. Father's Name (<i>First, Middle, Last</i>) William Patrick Hogan	-	Lena Mai	ne (First, Middle, N rie Hensl	ler			
, Mar	and 2 sho lealth and m 27 is ma her trauma		19a. Informant's Name/Relationship (Type. Print) Joni Bates (Daughter)	439 \$	ng Address (Street and Number or Ru Spry Island Road,	Joppa, M	Maryland 2	1085		
Baltimore,	it. Pages 1 rtment of F rtant; if ite			20c. Location - City or Town, State Baltimore, Maryland						
Ba	perm Depa Impo any ii		21. Signature of Fineral South Olicensee		Name and Address of Facility Bruzdzinsk 1407 Old Eastern	ESSEX, Mai	A. ryland 2122			
)	Physician /Medical Examiner		23a. Part1, Enter the disease, or complications that caused the deal shook, or heart failure. List only one cause on each line. Immedia ause (Final disease or condition resulting in death) Due to (or as a consection)	BET	er the mode of dying, such as cardiac ES MELLITO TENSION	or respiratory arre	HOE I	Approximate Interval Between Onset and Death		
68760,		ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consect of the consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Due to (or as a consect of the cause) Du	juence of):	C1121/	LEMIA	+			
.O. Box 68	ath certif attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetz 4 □ Pregnant at time of 6 9 □ Unknown	aldeath 3□	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year		
а_	w requires that the de been signed by the should be detached	ρχ	Part II. Other significant conditions contributing to death but not res	ulting in the ur	nderlying cause given in Part I.	23e. Did tob	es 2 10 3 P	o the cause of death? robably 4 □Unknown		
Records,	sician: The law rec s certificate has beel irector, page 2 shou	Completed	RIGHT BELOW 10	NOE	AMPU7A7100	24a. Was ar autops perform	y prior to death?	utopsy findings available completion of cause of		
Vital		Be C	25. Was case referred to medical examiner? Hospital: Hospital:		1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)					
Division or	or the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification: To	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 10	28b. Time of Injury	Njury Work? M 1 □ Yes 2 □ No					
۵	To the Hospital or within 24 hours aft. To the Funeral Di completely filled in	Medical Cer	29a. Certifler (Check only one) 1 ☐ CertifyIng Physician: To the best of my knot 2 ☐ Medical Examiner: On the basis of examine and manner stated.	owledge, death	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the ca	ause(s) and manner a	s stated. e to the cause(s)		
)	To the To the Comple	Mec	29b. Signature and title of certifier Which May Lay May.	MO	29c. License number	29	9d. Date signed (Mont	th, Day, Year) 1-200S		
	10x1		30. Name and address of person who completed cause of death (Iter		Print) CHESAC	o Are	BALTO,	1-200S MD21237		

State Registrar 31. Date filed (Month, Day, Year)

FEB 0 1 2008

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32, Registrar's Signature

			1 - For State Registrar	State of iv	iai yiailu /		ate of Dea		_	ene g. No. 20	08	02	615			
	Dhysisi	-	1. Decedent's Name (First, Middle	, Last)					2. Date of Deatl Month	Day	Year	3. Time o	f Death			
	Physici /Medi		Mildred Ange	la Hinz					January			2:33	РМ			
	Examir	ner	4a. Facility Name (If not institution	, give street and number)	4b. C	ty, Town, or Loca			4c. County	of Death					
*			Stella Maris					onium		I	3alti					
4	Funeral Director		5. Social Security Number 215–18–5571 Usual Residence of Decedent	6. Sex 7. A 1 ☐ M 2 X ☐ 4F	ge (In yrs. last b	Yrs. Month		Inder 24 Hrs. purs Min.	8. Date of Birth (Month, Day, July B,	Year) 1923	9. Birthpla Count Mary	ace (State d try) land	or Foreign			
	land ow tt		10a. State 10b. County		10c. City, To	wn or Location		-			10	d. Inside C	ity Limits			
	Mary -f shu iled a	호	Maryland Hai	rford		Jarr	ettsvil]	l o					2 No			
	r 28a	Directo	10e. Street and Number		1		Zip Code		10	g. Citizen of W	/hat Count	try?				
	th wit 23a o Ist be		4026 Old Federal	Hill Road			210	184			JSA					
	ems er mu	Funeral	11. Marital Status	12. Was Decedent	t Ever in U.S.	13. Was De	cedent of Hispan pecify Cuban, Me		cify Yes or No-	14. Race	- America					
21215-0036	be filed within 72 hours after death with the Maryland tall Hygiene. In a constant the Medical Examiner must be notified at event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced		No			ecity:	nican, etc.)	Specify:	k, White, e	nc. hite				
5-0	72 hc natu dical	Completed	15. Decedent (Specify only highes	's Education	16	a. Decedent's U	sual Occupation	most of working	ng 1	6b. Kind of Bu	siness/Indi	ustry				
21	within ene. than "	du	Elementary/Secondary (0-12)	College (1-4or	5+)		work done during use retired)	, mode of worth	'9							
2	filed v Hygie ther t	ပိ	12 17. Father's Name (<i>First, Middle,</i>	n/a_		Ho	memaker 	Mothor's Name	(First, Middle, M	At F						
Maryland	ould be f Mental I arked of atic eve	o Be	Charles Dorse	,			10.1		ra Colle		,					
<u>2</u>	g p E E	၉	19a. Informant's Name/Relationsh		19	b. Mailing Addre	ess (Street and N		Route Number,			Code)				
	d 2 Tis		Mr. Joseph W. H						Road Jar				21084			
Baltimore,	es 1 an of Heal f item 2 r other		20a. Method of Disposition		20b. Place	of Disposition (A ery, crematory of	lame of				c. Location - City or Town, State					
Ē			1 ☑ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Si		, ,		h Cemeter \	/ 2/2/20	08 t	3altimore	. Men	/land				
alt	permit. Pag Department Important: I any Injury o		21. Signature of Punera Service	Shee	0	The state of the s	and Address of F				, , , ,		204			
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			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Approximate interval Betw.													
	Physician		Immediate Cause (Final disease or condition resulting in death)	a.	Dew	ienhic	*				1	Onset and	Death			
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):										
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	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury		1											
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68760,	tificate be executed g physician and as the burial-transit			d												
	rtifical ng ph as th	fedical														
Вох	w requires that the death cer been signed by the attendir should be detached for use	Physician/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnancy 2 🗆 Fetal deat	h 3□Ectopio	nregnancy				of deliver					
<u>.</u>	e dea the at red fo	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a 9□Unknown		5 ☐ Other				Mon	ith [Day '	Year			
P.O.	d by I	Phy	9 ☐ Unknown Part II. Other significant conditio		out not requiting	im the comptended of	t- F	2-41	On Diding							
Records,	requires that the een signed by th	by	Talt II. Other significant conditio	is contributing to death t	out not resulting	ırı ine undenyinç	cause given in i	-απ ι.		acco use contri						
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چ	e la has	mp							24a. Was an autopsy	24b. W	ere autops rior to com	sy findings pletion of c	available ause of			
	The date	S							perform 1 Yes 2:		eath? □Yes 2	2□ No				
or Vital	ding Physiclan: n. After this certific funeral director,	Be	25. Was case referred to medical examiner?	Hospital:			Other:		(Check only one							
	Phys r this ral di	<u>د</u>	1 ☐ Yes 2 ♣No 27. Manner of Death	1 ∐ Inpati	ent 2 ☐ ER/O	utpatient 3 ☐ I Time of	JOA 45		e 5 Resider							
on	ding h. : Afte fune	tio	1-→Natural 5 Pending 2 Accident investiga	(Month, Da		Injury M	28c. Injury at Work? 1 ☐ Yes		od. Describe nov	rinjury occurre	ia					
Division	Attending r death. ector: After by the funer	fica	3 Suicide 6 Could not determine	ot be 28e. Place of ini	ury - At home, fa				8f. Location (Stre	et and Numbe	r or Rural	Route Num	iber.			
ă	al or	Certification:	4 Hornicide	building, et	tc. (Specify)				City or Town,	State)			,			
	Hosp 4 hou Fune tely fil	edical (29a. Certifier (Check only one)	Physician: To the best examiner: On the basis of and manner st	of examination a	e, death occurre nd/or investigati	ed at the time, da on, in my opinion	te and place, a , death occurre	nd due to the cau d at the time, da	use(s) and mar te and place, a	nner as sta nd due to t	ted. the cause(s	;)			
	To the within 2 To the сотрее	Me	29b. Signature and title of certifier		·-	2	9c. License num	ber	290	d. Date signed	(Month, D	ay, Year)				
				/ in .			Du3	17.5		1 (3)	108	S`				
1	07		30. Name and address of person v				VALLEY R	OAD	TIMON	IUM MI) 2.	1093				
	Sta		31. Date filed (Month, Day, Year)	38. Registr	rar's Signature	Araski)										

DHMH 17 Rev 1/2001

2:33 P.M.

JANUARY 30, 2008

HINZ, MILDRED

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Dorothy A. Hill Jan 29 2008 10:40p 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 37 Clipper Road Essex Baltimore 8. Date of Birth (Month, Day, Year) Jan 11,1922 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Days 1 □ M 2 □ X F 86 281-16-4885 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 ☐ Yes 217 No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37 Clipper Road 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hochschild Kohn Sales 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William English Mary Jane English 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon Hill Knightsbridge Court Baltimore MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 2/2/08 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State Baltimore MD 4 ☐ Donation / Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. Md 21. Signature of Funeral Service Linears e Connelly Funeral Home of Essex MI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): newten Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Ulnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Nnknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

by Funeral

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Director

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of Health and Mental Hygie I Item 27 is marked other I r other traumatic event, th

permit. Pages 1 Department of H Important: If Ite any Injury or ot

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the Maryland r 28a-f show notified at

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical þ Be ٩

burial-tran the as attending | for use as ed by the a detached for ate has been signed page 2 should be der

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Completed

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural

Certification:

completely filled in by the funeral

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica after death.

2 Accident 3 Suicide 4 Homicide 29a. Certifier Medical

State Registrar M.D

and manner stated.

28a. Date of Injury (Month, Day Year)

29c. License number 00055171

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an autopsy performed? 1□ Yes 2 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

Brenze Both

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SERASTIAN taster-3023

2008

1

Hospital:

5 ☐ Pending investigation

6 Could not be

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 0

determined

Solton

32. Registrar's Signature The same of the sa



1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Paula S. Hammen 2008 Jan 27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8613 Goldenwood Road Rosedale 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. March 29, 1934 1 □ M 2 ₩ F 218-28-5419 73 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Inportant: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Rosedale Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8613 Goldenwood Road 21237 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert L. Sadler Margaret Annen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret P. Burkett/daughter 12309 Eastern Ave. Balto. MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith 20a. Method of Disposition Date 20c. Location - City or Town, State Marial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2/1/08 Rossville MD 21. Signature of Fundral Service License 22. Name and Address of Facility 300 Mace Ave.Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the dise in e, shock, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Immediate Cause (Final disease or condition resulting in death) ow-Small Cell Lung **Physician** ILE TASTATIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): that initiated events resulting in death) Last signed by the attending physician and deetached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an page 2 s autopsy performe 1∐ Yes 2 No Be

To the Funeral Director: After this certific completely filled in by the funeral director, To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After

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Certification:

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24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier

and manner stated. 29b. Signature and title of certifie

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hilage/phir

MD

1 ☐ Yes 🏖 ☐ No

Approximate Interval Between Onset and Death

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Year

Registrar

	-	For State Registrar	State of Ma	aryland / Dep	artment of			giene 008	02618
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- dea	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of If Yes, specify Cu	Hispanic Origin? Iban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	- 14. Race - Ar Black, Wi	nerican Indian, nite, etc.
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-00 Phour	edt	15. Decedent's E	ducation	16a. Dec	edent's Usual Occ	upation		16b. Kind of Busines	White ss/Industry
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ryla hould d Mer mark matic	၉	James Marion Ho 19a. Informant's Name/Relationship		19b Mai	ling Address (Stre		nia May F	or, City or Town, State	. Zip Code)
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ore, M		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other p	lace)	Date	20c. Location - City	or Town, State
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "neturel", or Items 23a or 28e-1 ehow any injury or other treumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Lice	nsee		McComas	ress of Facility Funeral	Home, P.A	١.	
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Of Phys	<u>۲</u>	1 Yes 2 PNo 27. Manner of Death	1 ☐ Inpafie 28a. Date of Inju		BITE SI DOA	4 🗀 NUISIN		dence 6 Other (S how injury occurred	pecify)
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te Hospil 24 hour 16 Funeri	Medical (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	f examination and/or	ath occurred at the investigation, in m	time, date and pl y opinion, death o	lace, and due to the occurred at the time,	cause(s) and manner date and place, and o	as stated. due to the cause(s)
To th withir To th	W	29b. Signature and title of certified	Theran	Som	29c. Lice	anse number	5	29d. Date signed (MC)	Py 2008
30		30. Name yang address of person yang	gompleted Autre of	leath (Item 23a) (Typ		BEL	AR RI	JANUA JAD YLAND	21047
Sta Registr		31. Date filed (Month, Day, Year)	08 32. Registr	ar's Signature	assi		0		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:30 Fin abeth Dimes Lanuar /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CTC Baltimore theaden Rehals NA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 N C 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 8/20/18 **Funeral** Months Days Hours 10 M 20 F -14-9 Director Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □ Yes 2 □ No Be Completed by Funeral Director MD NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Depermant of Health end Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be 1217 West Fayette ST. U.S.A 21223 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ※☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: 3€ Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Nursing Assistant 12th Grade NA 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Elmo Patterson Marquarite Newmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Frances-Brooks 1415 N.Ellwood Ave Baltimore, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐Donation 5 ☐Other (Specify) National Mem Park 2/4/08Laurel MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H East 1101 E.North Ave Baltimore, MD 21202 23a. Pert1. Enfer the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner After this certificate has been signed by the attanding physician end funeral director, page 2 should be datached for usa as the burial-transit or Attending Physician: The law requiras that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events Due to (or es/e consequence of) Division of Vital Records, P.O. Box 68760, that initieted events resulting in death) Last Due to (or as a consequence of): Part II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No δ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 🗆 Yes 2 2 No 1 ☐ Yes 2 ☐(No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 3□ DOA 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Naturel 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the form 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital of within 24 hours er To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier U Nach 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 501 ACEM 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 16 Rev 6/95

Registrar

			1 - For State Registrar	State of Maryla		rtificate of		-	Reg. No	0.0	00000	
	Physici	án	Decedent's Name (First, Middle, Last	t)				2. Date of De		-Year -	3. Time of Death	
	/Medi		Joseph M. Julia					JANUH	RYDay30.		11:46Ам	
)	Examir	ner	4a. Facility Name (If not institution, give Saint Joseph	Medical Ce	nter		r Location of Death TOWS			y of Death Balt	imore	
2 24	Funeral Director		5. Social Security Number 6. Security Number 19 6. Security Number 19 19 19 19 19 19 19 19 19 19 19 19 19	7. Age (<i>In yr</i> 73	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 26	th ay, Year) 1934	9. Birthp Cour	place (State or Foreign htry) MD	
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	th with th 23a or 26 1st be no	al Dire	10e. Street and Number 13815 Manor Road			10f. Zip Code	21013		10g. Citizen of USA	What Cour	ntry?	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2K No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No Rican, etc.)	14. Ra Bla Speci	ce - Americ ack, White, fy: Wh		
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Baltimore,	ges 1 t of He If item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	20b Removal from State	. Place of Dispo cemetery, cre	osition (Name of matory or other plac	ce)	ate	20c. Location	- City or To	own, State	
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Bal	permit. Pages 1 Department of H Important: If ite any Injury or ot		21. Signature of Funeral Service Licens	> Rue k	\sim	2. Name and Addre	ss of Facility Sc r Rd. Not		k Funera		me Inc.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician David W. Jewell, Jr. January 27, 2008 /Medical 5:11 P 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 24, 19 9. Birthplace (State or Foreign Country) Virginia 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1X M 2 ☐ F 63 230-56-3717 Director 1944 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5343 Strathmore Avenue 20895 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1∐Yes 2XÎNo þ White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Wholesaler Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David W. Jewell, Sr. Katherleen Whitlow ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Tyler Jewell/Wife 5343 Strathmore Avenue, Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State January 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Bethesda, Maryland 2008 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee unilian a. M01173 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final terroscleratic cardiovascular Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events could be active to the cause of Due to (or as a consequence or, Examiner resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □ Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Jewell, David 1/27/08 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Peath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation (Month, Day Year) 1___atural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01/2 7/2008 55410 Gucherman, InD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
YEVGENIY GINCLEMAN, M.D. 3600
Bene Print) Did Desda 10

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0

32. Régistrar's Signature

physician and is the burial-trans Division or Vital Records, P.O. Box 68760, attending pl ed by the a detached f cate has l To the Hospital or Attending Physician: funeral director, within 24 hours are.

To the Funeral Director

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ir than "natural", or Items 23a or the Medical Examiner must be

Director

Funeral

Be

Examiner

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

al Hygiene.

f Health and Mental Hygie Item 27 Is marked other I other traumatic event, the

permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

1501 State

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)



ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00770 State of Maryland / Department of Health and Mental Hygiene Sung Hoon Jung Certificate of Death 1- For State Reg. No Registrar 3. Time of Deat Date of Death 1. Decedent's Name (First, Middle,Last) Month Day January 28, 2008 Physician/ 1001 hrs Medical Examiner Hoon Jung Sung 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Howard Baltimore Howards County General Hosptial 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) 5. Social Security Number Country) **Funeral** Months Days Hours Min 04-03-1982 Kcrea Director 25 1X M 2 F Yrs None Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Yes 2 XXNo "natural", or items 23a or 28a-f show Examiner must be notified at once. Ellicott City Howard Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21043 Korea 4802 Lee Hollow Place 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married Married Yes 2 X No Specify: Asian imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.

I anti: If item 27 is marked other than "natural", on other tranmaft event, the Medical Examinet. Yes 2XX No specify: If Yes. Give Year ⋧ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Finance Accountant $^{4+}$ 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Youngok Ahn Be Moon Chun Jung 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4802 Lee Hollow Place, Ellicott City, MD 21043 Youngok Jung - mother 20c. Location - City or Town, State Feb. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition timore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of 01,2008 Elkridge, Maryland Meadowridge Mem. Pk. Donation 5 Other Specify 21. Signature of Funeral Service Licer 22 Name and Address of Facility Gary L. Kaufman Funeral Home at 7250 Wash. Blvd., Elkridge, Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Death 'Medical Myocarditis Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit requires that the death certificate be executed Physician/Medical AMENDED 27, perME, g877, attending physician a X UNPENDED 3/5/08 TI Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Dther significant conditions o Yes 2 ✔ No 3 Probably 4 Unknown Š σ. pleted 24b. Were autopsy findings available Records. 24a. Was an certificate has been prior to completion of cause of autopsy The law r performed? death? Com 1 🗸 Yes No ✓ Yes 2 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical of Vital Be Other₄ examiner? Hospital: 1 Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death tification: Yes 2 No 1 X Natural Division Pending Director: d in by the f 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc hours after 3 Could not be or Town, State) Suicide Certi determined 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. o the Bo. within 2' To th **Medical** Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 29, 2008 O.C.M.E. creek 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 32. Registrar's Signature State Registrar

OCME

ORIGINAL

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

GRA

FEB 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

DHMH 17 Rev 1/2001

SHEINFELD 32. Registrar's Signature

D0066335

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Foamend #17,18&19a Per INF C8/6 2/20/08 THE Registrar Amend #18, perFH,g876, 2/1/08 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 Kerney January Wesley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Marin Good Luck Koad If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, May 8 1937 7. Age (In vrs. last birthdav **Funeral** Months Days 1X M 2□ F 306-36-1490 70 May Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notifiled at 1 ☐ Yes 2 ☐ No Director Maryland Prince George Lanham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20706 USA 9857 Good Luck Road Apt 8 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☒ No Specify. þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Library of Congress U.S. Gov. Translater 18. Mother's Name (First, Middle, Maiden Surname) Lean May Penticuff 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Barney Kerney -Unknown Delmar Leah Penpicuff 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 i Wesley E. Kerney 1141 Double Chestnut Ct. Curtis Bay Md 21226 son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If its any injury or o 1 ☐ Burial 2 ☐ *Cremation 3 ☐ Removal from State Metro Crematory Inc. 1/31/08 Baltimore MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Serv Stallings Funeral HomeP.A. 3111 Mountain Road Pasadena MD 21122 items that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comclic shock, or heart failure. List only on-Immediate Cause (Final Physician Therose eral, an disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner **P**g certificate be executed burial-transit Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. 1 □ Yes 2 □ No detached the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate 1∐ Yes 2 NO To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examinera 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Inpatient 2 ER/Outpatient 3 DOA 은 To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: (Month, Day Year) 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident investigation the f Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

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State

31. Date filed (Month, Day,

Year

2008

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3. Registrar's Signature

d

arbara Keiser		State of Maryl - For State Registrar		ent of Health and ate of Death	d Mental Hy	giene Reg. I	No. 200	8 02626			
Physician	1/	1. Decedent's Name (First, Middle,Last)				Date of Death Month Da	ay Year	3. Time of Death 0849 hrs			
Medical Examine		BARBARA ANN KETSER 4a. Facility Name (if not institution, give street and n	umbar)	Ab City Town or	Location of Death	Month Da January 21,	2008 4c. County of Death				
		124 North Curley Street	umber)	Baltimore	Location of Death						
Funeral Director		5. Social Security Number 6. Sex 1 M 2XF	7. Age (In yrs. last birth	nday) If Under 1 Yea Months Day		8. Date of Birth(N	MM/DD/YYYY) 9. Bir Foreig Co				
au ·		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits			
<u> </u>	۱,	MD	BALTI	MORE				1 X Yes 2 No			
Maryland 28a-f show d at once	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	ntry?			
with the Maryland ns 23a or 28a-f sho be notified at once		124 N. CURLEY ST.		21224			USA				
ath wi items	Funeral	1 Never Married 2 X Married Armed		 Was Decedent of His If Yes, specify Cubar 			14. Race - Amer White, etc.	ican Indian, Black,			
15-0036 filed within 72 hours after death with the Maryland Hygiene. ed other than "natural", or itens 23a or 28a-f shr t, the Medical Examiner must be notified at once		3 Widowed 4 Divorced If Yes, Give You	2 X No	1 Yes 2 X No	specify:		Specify: WH	TE TE			
hours afte	g S	15. Decedent's Education (Specify only highest gr		Decedent's Usual Occupa during most of working life			b. Kind of Business/	Industry			
36 in 72 h han "n lical E	Completed	, , , ,	1-4 or 5+)		Do No 1 doo 10	00)	DECMATIDAT	.arm			
5-0036 led within 72 Hygiene. other than the Medical	<u>E</u>	12TH 17. Father's Name (First, Middle, Last)	l W	AITRESS	18.Mother's Name	RESTAURANT ame (First, Middle, Maiden Surname)					
21215-0036 ould be filed within 7 Mental Hygiene. Is marked other than ic event, the Medica	Be	JACOB F. IHLE			BARBARA	BAKER					
O & B is it i	္	19a. Informant's Name/Relationship (Type, Print)	1	o. Mailing Address (Stree				1			
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,	-	WILLIAM F. KEISER 20a. Method of Disposition		24 N. CURLE of Disposition (Name of ce		LTIMORE,	MD 2122				
Ore ges l a t of He		1 X Burial 2 Cremation 3 Removal	i	ory or other place)	1	i	•				
Itim iit. Pa irimen ortant cy or o	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee			BALTIMORE						
Ba perm Depa Imp		Wesley Chan	SLEY CHAVIS, JR. FNRL. HM. WE., BALTIMORE, MD 21231								
Physician		23a. Part I. Enter the disease, or complications that failure. List only one cause on each line.	respiratory arrest	, shock, or heart	Approximate Interval Between Onset and						
/Medical Examiner	ì	Immediate Cause (Final disease a. Atherosci			Death						
		,	a consequence of):								
	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	a consequence of):								
1/ -	Examiner	(Disease or injury that initiated C.	a consequence of):								
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. Ithe Funeral Director: After this certificate has been signed by the attending physician applietly filled in by the funeral director, page 2 should be detached for use as the burial - transit	등 - (관	d		-							
50, ate be execut hysician and e burial - tra	Physician/Medical	UNPENDED AMENDED									
6876 certificate ading phy	<u> </u>	22h Mas decedent progrant in the	, outcome of pregnancy birth 2	Fetal death 3	Ectopic pregna	псу	23d. Date of deliver Month	y Day Year			
Box 68760, edeath certificate be exche attending physician dor use as the burial	Sicia	1 Ves 3 of No 0 Heknows 4 Pre-		Other (Specify)			Vii				
that the de ned by the detached f	ᇍ		nown to death but not resulting	g in the underlying cause	given in Part I.	23e. Did toba	cco use contribute to	the cause of death?			
P.O.		Diabetes Mellitus				1 Yes	2 🗸 No 3 Pro	bably 4 Unknown			
of Vital Records, ig Physician: The law requirement of the thin the certificate has been smeral director, page 2 should	Completed by					24a. Was an autopsy		utopsy findings available completion of cause of			
Reco The law icate has	틹					performe	ed? death?	es 2 No			
tal Recians The certificate	ပ္က မရ	25. Was case referred to medical		26.Plac	e of Death (Check						
Vital Insician:	ၟႍႃ	examiner? 1 ✓ Yes 2 No Hospital: 1		utpatient 3 DOA			esidence 6 🗸 Othe	er: Scene			
n of ding Phy		27. Manner of Death 1 Natural 5 Pending 28a. Da (Mor	e of Injury 28b. 1		ury at Work? Yes 2 No	28d. Describe how	w injury occurred				
Division fal or Attendi rs after death. al Director: /	<u>g</u>	2 Accident Investigation 28e. Pla	ace of Injury - At home, fa	arm, street, factory, office		28f, Location (Stre	eet and Number or R	ural Route Number, City			
Division pital or Attend ours after death neral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specification of the determined of the determin		, 5554, 1557, 555		or Town, Stat					
Hospi 24 hou Funer funer itely fil		29a. Certifier 1 Certifying Physician: To the b									
Divis To the Hospital or A within 24 hours about some completely filled in b.	Medical	one) 2 Medical Examiner:On the basi and manner									
	Ž	29b. Signature and title of certifier		29c. Licen			29d. Date signed (Mo				
		/ alistens	<u> </u>	0.0	.M.E.		January 22, 200 				
7		 Name and address of person who completed ca Laron Locke MD. Assistant Medic 	, ,	1 Penn Street, Balti	imore, MD 212	01					
Sta	te	31. Date filed (Month, Day, Year) 32.	Registrar's Signature	Sante)							
Registr	ar	FEB 0 1 2008	Markey for	1							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First Middle, Last. PAUS Day **Physician** 01-28-08 2:30 A /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner 4216 ½ Silver Spring Road Baltimore Perry Hall Under 1 Year | If Under 24 Hrs. onths | Days | Hours | Min. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday Funeral 10-08-1926 1 □ M 2 □ F 81 Director 219-10-3282 Usual Residence of Decedent the Maryland 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director MD Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 4216 ½ Silver Spring Road 21128 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☑ Married White 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 House Wife Own Home Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Trentler Marie Howard 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 | Elmer P. Kraus/Husband 4216 ½ Silver Spring Rd. Perry Hall MD 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Joseph Cemetery 02-02-08 Baltimore MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. Defalere 9705 Belair Rd. Nottingham MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) D1435759 **Physician** /Medical Due to (or as a consequence of) Examiner ISCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dubito for as a consequence of Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical as the I 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 2 No detached 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 3 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 12 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Besidence 6 Other (Specify) 1 | Yes 2 | 1 | No Certification: To 1 Inpatient 2 ER/Outpatient 3∐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation tural 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, P.O. Box 68760, After this

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

State

Medical

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

nancis 31. Date filed (Month, Day, Year)

FEB

Registrar

7505

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Oslen Dr

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Marylar		nt of Health and te of Death	Mental Hygier	2000	02628
	Physici /Medio		Decedent's Name (First, Middle, Last	Spratlin	Kloti	1	2. Date of Death Month JAN. 2	Pay 2008	3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give	ritan Hos	pital	y, Town, or Location of Deat BALTI MOR er 1 Year If Under 24 Hrs s Days Hours Min.	h LE		place (State or Foreign ntry)
	the Maryland 28a-f ehow	ector	Usual Residence of Decedent 10a. State 10b. County 10e. Street and Number	10c. Ci	ty, Town or Location	A CM	100.6	70 710010	10d. Inside City Limits 1 ☐ Yes 2 1 No
92	d within 72 hours after death with the Maryland Jiene. r then "natural", or items 23a or 28a-f ehow the Medical Examinar must be natified at	y Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give	I.S. 13. Was Dec	21057 edent of Hispanic Origin? (S eacify Cuban, Mexican, Puer 211 No Specify:	pecify Yes or No-	USA 14. Race - Ameri Black, White, Specify:	can Indian,
21215-0036	yiene.	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	Year or Dates:	16a. Decedent's Us	ual Occupation work done during most of wo use retired)	rking	Kind of Business/Ir	
aryland;	be filed atai Hyg ad othe event,	To Be C	17. Father's Name (First, Middle, Last)	Spratlin			me (First, Middle, Maid		
Σ.	Pages 1 end 2 should nent of Health and Mer int: If item 27 is marke iry or other traumatic		19a. Informan's Name/Relationship (7) HOLLY WHO - 20a. Method of Disposition 1 Burial Command 3	Spouse 20b. Removal from State	19b. Mailing Addre	ss (Street and Number or Ri ame of other place)	z, Glen 1	y or Fown, State, Zij	21057 own, State
Baltimore	permit. Pag Department Important: any njury o		4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens	114	I KLUCCO (f 22. Name EVA AS I	nateu 121 and Address of Facility		altimore Baltimore on Services	MD emozizad. Packville
	Physician /Medical Examiner	16	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	icatighs that baused the dea ne cruse on each line. Due to (or as a consect to the consect to t	juence of):	Failure	correspiratory arrest,	ilue	Approximate Interval Between Onset and Death
8760,47	death certificate be executed e ettending physicien and id for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect	theray	ry			oucel.
.O. Box 6	the y th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3 □Ectopic			23d. Date of deliv Month	very Day Year
ords, P	w requires thet been signed b should be dete	Ď.	Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlying	cause given in Part I.		o use contribute to I	14
of Vital Records,	The law ete has b page 2 sl	e Completed	25. Was case referred to medical			26 Place of De	24a. Was an autopsy performed: 1 Yes 2 1 ath (Check only one)	prior to co	opsy findings available ompletion of cause of
	ing Phys After this funeral dir	ation; To B	27. Manner of Death 1 Accident investigation	Hospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	Other	dome 5 ☐ Residence 28d. Describe how in		ify)
Division	ospitet or Attenchous efter death hours efter death uneral Director: ily filled in by the	Certification	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	(y)		28f. Location (Street City or Town, Sta	ate)	
	To the Hospitel or At within 24 hours effer of To the Funeral Directompletely filled in by	Medical	29a. Certifier 1 Certifying Phyone) 2 Medical Examone) 29b. Signature and title of certifier	ner: On the basis of examination manner stated.	ation and/or investigation	d at the firms, date and place on, in my opinion, death occu-	urred at the time, date a	(e) and manner as and place, and due to Date signed (Month,	to the cause(s)
}	10		30. Name and address of person who c	Jele ompleted cause of death (ite	m 23a) (Type, Print)	020396 Paven Klu	Ja	muary	30,2008
	Sta Registr		31. Date filed (Month, Day, Year)	In 5601 Registrar's Sign	hech 1	laven Blu	el Bak	+ move	md 21239

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	3	k .	Registrar 1. Decedent's Name (First, Mid	idle, Last)		001	imouto	0, 0	can		2. Date of De		4	UÜ	3. Time of Death
	Physici		Samu	iel M. Ki	rkwood						JAMUE	ARY Day	29,8	Y27218	12:29Рм
	/Medic Examin		4a. Facility Name (If not institut Saint Jose	ion, give street and nur 2 Dh Medic	mber) al Cer	iter	4b. City, To	own, or Lo		Death WS 0	n	4c. (County (of Death	imore
	uneral irector		5. Social Security Number 213-01-0061	6. Sex 1 X M 2□ F	7. Age (<i>In yr</i> s. 91	last birthday) Yrs.	If Under 1 Months		If Under 2	4 Hrs. Min.	8. Date of Bir (Month, Day May 24	rth ay, Year) 1, 19	16	9. Birthpla Count Mary	ace (State or Foreign Tand
pun	>		Usual Residence of Decedent 10a. State 10b. Coun	hy	10c Cit	tv. Town or Lo	cation							10	d. Inside City Limits
Maryla	f sho	ō		timore		owson								1.0	1 ☐ Yes 2 📉 No
the	r 28a- notif	Director	10e. Street and Number				10f. Zip C	ode				10g. Citiz	en of W	/hat Count	try?
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36	", or l' camin	by Fi	1 ☐ Never Married 2 🛣 Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, Giv	/e		1 □ Yes 2	No .	Specify:			Specify: White			e
d 21215-0036 filed within 72 hours after death with the Maryland	atural cal E	ed	15. Deced	ent's Education	utos.	16a. Dece	dent's Usual	Occupation	on					siness/Ind	
215 Eii 7	an "n Medl	Completed	(Specify only high Elementary/Secondary (0-12	nest grade completed) College (1	I-4or 5+)	1 _	kind of work DO NOT use		ring most (of workin	g			. .	
6 d 7	ner th			<u> </u>		ACC	countar		0.14-15	- 11	Accounting				
Maryland 21215-0036 nd 2 should be filed within 72 hours af	and mental rivel is marked other aumatic event, t	Be c	J. Lukey Kir	e, Last) *Kwood		18. Mother's Name							Surnam	e)	
aryla should I	mark mark imath	욘	19a. Informant's Name/Relatio										Town,	State, Zip	Code)
e, Ma 1 and 2	27 is		Mr. David Kirk	kwood/ Son		1226	Buck	Horr	n Rd.	Syk	cesvill	le, M	d. 2	21784	
Baltimore,	r oth		20a. Method of Disposition 1 Burial 2 □ Cremation	3 DRemoval from		Place of Dispo cemetery, crei	sition (Name matory or oth	of er place)	6 6	Da	ate			City or Tov	
limor Pages	tant: I		4 □ Donation 5 □ Other	(Specify)	Du	laney \	•			2-1-0		l	imonium, Md.		d
Baltii permit.	Department or realing and without any other was trained and selected any injury or other traumatic event, the Medical Examiner must be notified at one.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility RUCK TOWSON Funeral Home, Inc. 1050 York Rd. Towson, Md. 2120 23a. Part1. Ent in the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,													
75			23a. Part1. Ent r the disease, shock, or heart failure. L	or complications that clist only one cause on e	aused the deat	th. Do not ent	er the mode	of dying,	such as c	ardiac or	r respiratory a	arrest,		13	Approximate Interval Between Onset and Death
	sician		Immediate Cause (Final disease or condition resulting in death)	_a. INT	RAVENT	RICUL	AR HE	MOR	RHAG	ìΕ					4 HOURS
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pe	nsit ,	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a consec	quence of):			Prov	ped	dia	Dol	11	2	
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	as th	Medi	IE EEMALE.						16	w	26	- 1			
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that	been signed by the should be detached	by Ph	Part II. Other significant cond	itions contributing to de	eath but not res	sulting in the u	nderlying cau	ıse given	in Part I.		23e. Did	tobacco u	se contr	ibute to the	e cause of death?
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Division or Vital To the Hospital or Attending Physician:	within 24 totus are forean. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ledical	29a. Certifier 1 Certify (Check only one) 2 Medic	ying Physician: To the al Examiner: On the b	e best of my kno asis of examina ner stated.	owledge, deat ation and/or in	h occurred at vestigation, i	t the time n my opir	e, date and nion, deat	l place, a h occurre	and due to the ed at the time	e cause(s) e, date and	and ma I place, a	nner as st and due to	ated. the cause(s)
o the	omple	Med	29b. Signature and the of certi	1	ner stated.		29c.	License n	number			29d. Dat	e signe	d (Month, L	Day, Year)
	> - 0		ATO	1			n	476	25			1/3	30/	80	
,	7		30. Name and addiess of person	on who completed caus	se of death (Ite	m 23a) (Type,	Print)								
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2	Sta Registi		31. Date filed (Month, Day, Yea	ar) 32. F	Registrar's Sign	ature.	hoosk	ş							
DHMH 1	17 Rev 1/2		i fan in	2 do		2					-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 JAN 26 4:23 P M WILLIAM MICHAEL KILBOURNE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY **BETHESDA** NATIONAL NAVAL MEDICAL CENTER 8. Date of Birth (Month, Day, Year) Jan. 17, 2008 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Months Min. Days Hours 1X M 2□ I Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Montgomery Village Marvland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20886 8846 Thomas Lea Terrace United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carly R. Ellenberger Michael J. Kilbourne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8846 Thomas Lea Terrace, Montgomery Village, MD 20886 Michael J. Kilbourne/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State January 31, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Chase Inc 21. Signature of Funeral Service M00198 7557 Wisconsin Ave., Bethesda, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EXTREME PREMATURITY Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

5

"natural", or items 23a

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner

Baltimore, Maryland 21215-0036

death with the

Examiner must be notified at

Director

Funeral

2

Completed

Be

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/Medical

None

10a. State

or Attending Physician: The law requires that the death certificate be executed use as the burial-trans the attending physician signed by the at d be detached for After i Director: in by t within 24 hours a To the Funeral

Division or Vital Records, P.O. Box 68760,

Medical

Examiner Completed by Physician/Medical Certification: To Be

IF FEMALE: 25. Was case referred to medical 27. Manner of Death

State

the

Registrar

23b. Was decedent pregnant in the past 12 months? 9 Unknown

examiner?

1 X Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

1 ☐ Yes 2 📉 No

24a. Was an autopsy perform 1□ Yes 2 X No 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 TYes 2 No

28a. Date of Injury (Month, Day Year) Injury 5 Pending investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🔀 Inpatient

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 TYes 2 TNo

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier nestay

25MA07382700 (NJ)

29d. Date signed (Month, Day, Year) 01/28/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600

NICOLE R. DOBSON 31. Date filed (Month, Day, Year) FEB 0 2008

CPT MC USA 32 Registrar's Signature

2 ER/Outpatient 3 DOA

28b. Time of

Division or Vital Records, P.O. Box 68760.

				lack Indelible Ink.		_	
	•	1 - State Registrar	e of Maryland	d / Department of F Certificate of		lygiene Reg. No. 2008	02631
Physici /Medic		1. Decedent's Name (First, Middle, Last) RITA K		KRONGARD	2. Date of Month Tanuar	Day Year	3. Time of Death 8. 02 \$309M
Examin		4a. Facility Name (If not institution, give street an SINEY HUSPIFEL OF BC	4 5	Baltin	r Location of Death	4c. County of Dea	ath
Funeral Director		5. Social Security Number 220-40-9806 6. Sex 1 □ M 212	7. Age (In yrs. In 96	ast birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Hours Min. 08/1	Birth 9. Bi (2) Pay, Year) 4/1911	rthplace (State or Foreign Country) MD
faryland show	or	Usual Residence of Decedent	10c. City	, Town or Location	TILLE		10d. Inside City Limits 1
with the Manageria or 28a-f	Director	10e. Street and Number 202 BRIGHTWOOD CLUB I	RNAN	10f. Zip Code	1093	10g. Citizen of What C	country?
filed within 72 hours after death with the Maryland Hygiene. Hygiene, wither than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	by Funeral	11. Marital Status 12. Was Arme	Decedent Ever in U.Sed Forces? Yes 2 X Nos, Give or Dates:		iispanic Origin? (Specify Yes or an, Mexican, Puerlo Rican, etc.) Specify:		ite, etc.
permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natura any injury or other traumatic event, the Medical Eonce.	Completed	15. Decedent's Education (Specify only highest grade comple	1	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working d)	16b. Kind of Business	·
filed wi Hygien other th		17. Father's Name (First, Middle, Last)	2	HOMEM	AKER 18. Mother's Name (First, Mid		HOME
should be nd Mental marked o	To Be	ABRAHAM	KEYSE	,	ETHEL		TAINABLE
and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship (Type. Print ALVIN KRONGARD / SON		1400 W. SEMI	and Number or Rural Route Nu NARY AVE., LUTI		•
Pages 1 nent of Hi int: If iter		20a. Method of Disposition 1	from State AGU	ace of Disposition (Name of DAS ACHIM ANSHI RD CONG.	Date 01/31/2008	ROSEDALE,	
permit. Departn Importa any inju		21. Signature of Funeral Service Lipedsee	20 e h	22. Name and Addre	ss of Facility SOL LEV	INSON & BROS	
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ysiclan: The second sec	To Be	25. Was case referred to medical examiner? 1 Yes 2 (No Hospital:	1 X Inpatient 2□E	ER/Outpatient 3 DOA Oth	26. Place of Death (Check on er: 4 ☐ Nursing Home 5 ☐ R		ecify)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to	Certification: T	1\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Date of Injury (Month, Day Year) Place of injury - At hob building, etc. (Specify	me, farm, street, factory, office	y at	be how injury occurred In (Street and Number or F	
e Hospita 24 hours e Funeral letely fillec	Medical C	(Check only 2 Medical Examiner: On	o the best of my know the basis of examinat manner stated.	wledge, death occurred at the ting ion and/or investigation, in my of	me, date and place, and due to opinion, death occurred at the tire	the cause(s) and manner and di	as stated. ue to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier	M. O	29c. Licens		29d. Date signed (Mon	
~~		30. Name and address of person who completed			5-000.	January.	50,2000.
Sta	to.	Kapil - Dangwal 31. Date filed (Month, Day, Year)	2. Registrar's Signat	23a) (Type, Print) NOI - HOSPIROL Ure	of Bultimore	9	
Sta Registr		FEB 0 1 2008	War Jo	State of the state			

	1	For State Registrar	State of Ma	ryland		rtment of H tificate of L				g. No. 2	008	1263
Physicia	_	Decedent's Name (First, Middle, La. ELAINE	st)			KLINE			2. Date of Death		3. 9, 2008	Time of Death 1:53AM
/Medica	al	ta. Facility Name (If not institution, give Saint Joseph	e street and number)	Cen	ter	4b. City, Town, or	Location	of Death	on	4c. Cou	unty of Death Balti	more
Funeral Director		5. Social Security Number 6. S		(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth) ⁷ 28		(State or Foreign
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within 72 hours after death with the Maryland ene. "Han "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	ţō	MD BALTIM	ORE		PIKE	SVILLE						☐Yes 2XNo
or 28a e notii	Funeral Director	10e. Street and Number				10f. Zip Code	0100	20	10		of What Country?	
s 23a	eral	13 POMONA SOUTH,	API. 4	ver in U.S.	13. \	Nas Decedent of Hi f Yes, specify Cuba	2120		cify Yes or No-	14.	Race - American In	ndian,
l", or item xaminer r	by Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🕅 N If Yes, Give Year or Dates:		l l	fYes, specify Cuba 1□Yes 2 K INo	n, Mexica Specify		Rican, etc.)	Ì	Black, White, etc.	ГЕ
to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5-	+)	(Give life. L	dent's Usual Occup kind of work done of DO NOT use retired MEMAKER	ation during mod ()	st of workin			of Business/Industr	У
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fental I	To Be	LOUIS		FISHE				ARAH			MAGED	
h and N 7 is ma trauma		19a. Informant's Name/Relationship GAIL KUSHNER /				ng Address (Street BOSWELL			POTOMA	r, City or To	own, State, Zip Cod 208	₅₄
penini. Tages I am Department of Healt Important: If Item 2 any injury or other once.		20a. Method of Disposition		20b. Pla	ace of Dispo	osition (Name of matory or other place	ce)				tion - City or Town,	
nent o		1 Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Spec		_ L ARb	NO CO	N CHIZUK NG.			/2008		IMORE, M	
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the attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	□Ectopic pregnanc □ Other (specify) _	у			230	d. Date of delivery Month Da	y Year
n signed by the a	by	Part II. Other significant conditions	contributing to death b	out not resu	ulting in the u	underlying cause gi	ven in Par	t I.	23e. Did to		e contribute to the o	V
te has been si age 2 should	Completed	<u> </u>							24a. Was autor perfo 1∐ Yes		death?	r findings avail letion of cause ≰ No
certificate rector, pag	Be C	25. Was case referred to medical examiner?	Hospital:			Ot	hori		h <i>(Check only o</i>			
After this certific funeral director,	은	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat	Hospital: 1 Inpati	ury	28b. Time Injury	of 28c. Inju	4		ome 5 Residence Reside I		Other (Specify)	
fter death Director: In by the	Certification:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of in	ijury - At ho tc. <i>(Specif</i> y	ome, farm, s	treet, factory, office			28f. Location (S City or Tox	Street and vn, State)	Number or Rural R	loute Number,
within 24 hours a To the Funeral C completely filled	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best caminer: On the basis of and mannyr's	of examina	wledge, dea	ath occurred at the investigation, in my	time, date opinion, d	and place, death occur	, and due to the rred at the time,	cause(s) a date and p	and manner as state place, and due to the	ed. ne cause(s)
vithin To the comple	Me	29b. Signature and title of certifier	1/			29c. Licer				29d. Date	signed (Month, Da	ay, Year)
		1	W				+635	6	(Jane	29	, 200
7		30. Name and a dress of person wi				e, Print) BLER DRI	r UE	TOL	SON. M	ARYL	AND 212	214
1	ate	31, Date filed (Month, Day, Year)	955 M. D. 32 egist	trar's Signa		MAN DR.	L T Inc 0	1 707 4 4				

DHMH 17 Rev 1/2001

Registrar

			Plea								Ensure A	-		•		
		For State Registrar		,	State o	it Ma	ırylan				lealth and l Death	Mental Hy	•			0000
		 Registrar Decedent's Nam 	ne (First, Midd	le, Last)				- 06	illica	ie or i	Death	2. Date of D		4 0 0 (3.	Time of Death
Physicia /Medic			othy S		Etwich	1						Month 01	29	y Year 2008	7	:05 A. M
Examin		4a. Facility Name (4b. Cit	y, Town, o	r Location of Death			County of Dea		
	24 5.		rist H		ce _				-	'OWSO				Balti		
Funeral		5. Social Security N 220-09-5		6. Sex	M 2[∑ F	7. Age		last birthday, 7 Yrs.	Months	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)			(State or Foreign
Director		Usual Residence o						' /				4/09/	1920	Ind	diana	ā
nyland how	_	10a. State	10b. County				10c. City	y, Town or L						_ <u>-</u> -		nside City Limits
ne Ma 8a-f s	Director	Maryland		timoı	re			Ba.	ltimo							□Yes 2 No
with the		10e. Street and Nu								ip Code				izen of What C ced Sta	ountry? Les	
eath v	Funeral	6131 N	orth C		es Str 2. Was Dec			S 13		21212 edent of H	lisnanic Origin? (S	necify Yes or N		Merica 14. Race - Am	erican In	dian.
r iten	Fun	1 ☐ Never Man	ried 21/2 Mar		Armed Fo 1 ☐ Yes	orces? 253 N					lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)		Black, Wh	te, etc.	
ral', o	l by	3 🗌 Widowed	4 Divorced	t	If Yes, Gi Year or D	ive Dates:			1 ∐ Yes	2 <mark>I</mark> I No	Specify:			Specify:	whi	te
72 hc 'natu dical	Completed	(Spe	15. Deceder					16a. Dece (Give	edent's Us e kind of v	ual Occup vork done	pation during most of wor d)	king	16b. K	ind of Busines	s/Industry	/
within sne. than	ldm	Elementary/Seco	ondary (0-12) 12		College (1-4or 5	+) 4		<i>bo not</i> ibrar		d)		Dri	ivate S	rhoo	10
filled Hygie Sther		17. Father's Name		, Last)			4	1	IDLAL	Lan	18. Mother's Nan	ne (First, Middle			21100	15
lid be fental rked c	To Be	Anton	J. Sc	hwar	tz						Nina	B. Sch	wartz	Z		
shou and M s mai		19a. Informant's N				_		1			and Number or Ru					
and and ealth m 27 in er tr		Douglas		twich	n Jr./	/ sp					Charles S		,			nd 21212
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatla and Mental Hygiene. Important: If fire X7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dis 1 ☐ Burial 2	•	3 □Re	moval from	State	1 0	Place of Disp emetery, cre	ematory o	r other plac	pel- janı	Date larv	1	ocation - City o		
it. Pa rtmen rtant: njury		4 □ Donation			0 /		Eva	Ве	l Air	•	: 31 -	2008	1		•	Maryland
permi Depal Impo any Ir		21. Signature of Funeral Service Licenses Peaceful Alternatives Funeral & Cremation Ctr., I 23.25 York Road Timonium, Maryland 21093												Ctr.,P.A		
		23a. Parti. Enter	the disease, c	or complic	ations hat	caused	the deat	h. Do not er			ng, such as cardiad			arytan		oroximate erval Between
Physician		Immediate Cause	(Final	t only one											Ons	set and Death
/Medical		disease or condition resulting in death)	on	a.				UENCE of):	HVP	ANC	TION				Di	193
Examiner		Sequentially list or	onditions	b.	ga	517	OIN	TEST 1	WAL	- B	LEEDIM	9			DA	745
L B is	iner	Sequentially list co if any, leading to in cause. Enter Undo Cause (Disease or	mmediate erlying	Į	(Due to	(or as	a conseq	uence of):		/						11100
oe executed cian and ourial-transit	Examine	that initiated event resulting in death)	lS .	c.	Due to	(or as	CU fr	uence of):	110h						4	CARS
sician buria	_	ATRIAL FIBRILLATION								ONS				WEARS		
The law requires that the death certificate be the has been signed by the attending physici bage 2 should be detached for use as the bu	Physician/Medica			u.											/	
th cer endin	M/ue	IF FEMALE: 23b. Was deceder		23	c. If yes, ou 1□Live				□Ectopic	pregnanc	.v			23d. Date of d	-	
e deal he att	sicia	in the past 12 1 ☐ Yes 2 9 ☐ Unknow!	No			nant at	time of d		Other (, 			Month	Day	Year
s that the de ned by the a	Phy	Part II. Other sign		ions cont	ributing to d	leath hi	it not res	ulting in the	underlying	rause niv	en in Part I	23e Did	tohacco	use contribute	to the ca	use of death?
signe d be c	d by	LUPUS		10110	induing to d	104111 00	11 1101 100		IAB					!□ No 3□ I		- 4
w require been si should t	etec	CHRONIC	C. 10101	81/A	2				• -	7-0		24a. Wa				findings available
The lavate has	Completed											aut per	opsy formed?	prior to death?	comple	tion of cause of
l clan: T	Be Co	25. Was case refe	BOCY 7	al PE	10/A						26. Place of Dea	1□ Yes ath (Check only		o 1 □Y€	s 2	No
nysical nis cer	To B	examiner? 1 ☐ Yes 2	3 No	Н	ospital: 1 🗆	Inpatie	nt 2 🗆	ER/Outpatie	ent 3∐ I	OOA Oth		lome 5 ☐ Re		6 XOther (Sp	ecify) H	DSPICE
ng Pt		27. Manner of Dea	ath 5 ☐ Pendi	na	28a. Date (Mor	of Inju	ry / Yea <i>r</i>)	28b. Time Injury		28c. Inju Wo		28d. Describe				
tendl leath. tor: A the fu	cati	2 ☐ Accident 3 ☐ Suicide		tigation		6 1 - 1			M		Yes 2 No	00/ 1 - /	(0)			
or Al after d Direc in by	Certification	4 ☐ Homicide	-14	mined	build	e or injuding, etc	iry - At no c. (Specif	ome, farm, s	treet, tact	ory, office		City or T	(Street a) own, Stat	nd Number or i e)	rurai Hoi	ite Number,
spital ours neral filled		29a, Certifier	1 Certify	ing Physi	ician: To the	e best	of my kno	wledge, dea	ath occurre	ed at the ti	ime, date and place	e, and due to th	e cause(s	s) and manner	as stated	 I.
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, it	Medical	(Check only one)	2☐ Medica	l Examin	er: On the I and mar	basis of	examina	ation and/or i	investigati	ion, in my	opinion, death occi	urred at the time	e, date an	nd place, and d	ue to the	cause(s)
To the within To the comp	Me	29b. Signature and	d title of certifi	er	7				2		se number	29d. Date signed (Month, Day, Year)			10.4	
			ei	/	0	1	-			D	64395	5	VA	NUARY	29.	2008
1		30. Name and add			npleted cau	ise of d	eath (Iten	n 23a) (Type	Print)	100	- 8117	200	00.	non and	10 -	2.252
<i>پ</i>	to	31. Date filed (Mo.			, MO	Registra	ar's Signs	/V C/	147-12	501	, our ,	4	BHU	111111111111111111111111111111111111111	IND	21204
Sta Registi			EB 0 1		8	Rese		K A	342	,	, 8417 i					

29d. Date signed (Month, Day, Year) 28 JAN 2008

			_	State of Ma	ryland / Depa					egible.	
			1 - For State Registrar		Ce	rtificate of I	Death	Re	g. No. 2	8009	02631
Ь	Physic	ion	1. Decedent's Name (First, Middle, L	.ast)				Date of Death Month	Day	Year	3. Time of Death
	/Medi		Margene Haines Laws	son		,		JANUARY			12:45 A M
	Exami	ner	4a. Facility Name (If not institution, ga	ive street and number)		4b. City, Town, or	Location of Death		4c. C	ounty of Death	
			FutureCare Nursing		<i>t</i>	Arnold If Under 1 Year	If Linday 04 Um	0.5	Ar	ne Arund	le1
	Funeral			1 □ M 2√2/F	(In yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	Date of Birth (Month, Day,	Year)	9. Birth Cou	place (State or Foreign intry)
	Director		Usual Residence of Decedent		37			June 1, 1	920		OH
	yland iow		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	Mar- a-f sh	ţċ	MD Anne Arur	nde]	Severna_P	a n!c					. 1 ☐ Yes 2XXNo
	or 28;	Director	10e. Street and Number		Severilla_I	10f. Zip Code		10	g. Citize	n of What Cou	intry?
	th wit		9 Belleview Dr.			21146			LICA		
	ems er mu	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No-	14	. Race - Ameri Black, White	can Indian,
98	or it	F.	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐ No If Yes, Give X		1 ☐ Yes 2 ☐ No	Specify:	,,	5		hite
8	ural"	d by	3 Widowed 4 Divorced	Year or Dates:			-				
15-	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notifiled at	lete	15. Decedent's I (Specify only highest g	Education trade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of worki	ing	6b. Kind	of Business/Ir	ndustry
12	withii iene. than the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemake	*		Ow	n Home	
9	filed Hygi other ent, t		17. Father's Name (First, Middle, Las	st)			18. Mother's Name	(First, Middle, M	laiden Si	urname)	
<u>a</u>	ld be lental ked (To Be	John O. Woodnansee				Laura Lut	trell			
Maryland 21215-0036	2 should be f and Mental H Is marked of raumatic ever	-	19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address (Street	and Number or Rura	al Route Number,	City or 1	Town, State, Zi	p Code)
	and 2 allth		Donna Spencer	Daughter	9 Be	lleview Dr.	, Severna Pa	ark, MD 2	1146		
ore.	of He		20a. Method of Disposition	*X	20b. Place of Dispo	osition (Name of matory or other place	e) [Date 2	0c. Loca	tion - City or T	own, State
Ĕ	Page nent ant: If		f Burial 2 ☐ Cremation 3 d 4 ☐ Donation 5 ☐ Other (Spec	ify)	Sugar Grove		i	y 31, 20 0 ε	Wi	lmington	, OH
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	e see		2. Name and Addres	ss of Facility				
<u> </u>	8 9 E 2 8		K Gregor Fink	M01	148 4	26 Crain Hwy	y S., Glen !	Burnie, MD	210	61	
P			23a. Part . Enter the disease, or or should, or heart failule. List on	mplications that caused t ly one cause on each line	he death. Do not en	ter the mode of dyin	g, such as cardiac o	or respiratory arre	st,		Approximate Interval Between
Y	Physician		Immediate Lause (Final disease or condition	DEM.	SNTIA						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						
	LAGIIIIICI	_	Sequentially list conditions,	b. =							
	lsit / led	ine.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury	Due to (or as a	consequence of):						
	te be executed ysician and f	Examine	that initiated events resulting in death) Last Due to (or as a consequence of):								
760,	be e sician buria	calE									
687	ficate physics the			d							
Box	that the death certificate be executed ed by the attending physician and to detached for use as the bunal-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p		23	d. Date of deliv	verv			
	death a atte d for	icia	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							Month Day Year	
o.	t the	hys	9 □ Unknown	9□Unknown					1		
S, T	The law requires that the tte bas been signed by the bage 2 should be detache	by P	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use	contribute to	the cause of death?
ğ	w require been sig should b	ed b						1 □ Ye	s 2	No 3 ☐ Pro	bably 4 nknown
S	law requas been 2 should	Completed						24a. Was an		24b. Were aut	opsy findings available
ď	The I	E						autopsy perform 1 Yes 2	ed?	prior to co death? 1 □ Yes	ompletion of cause of 2 □ No
ţa	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Death		No	1 Lifes	21110
>	nysic lis ce direc	TOE	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatier	nt 3 DOA Othe	er: 4 Nursing Ho	me 5 ☐ Resider	nce 6 l	□Other (Speci	ify)
0	ding Ph		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		f 28c. Injun Work		28d. Describe hor			
Sio	Attending Physician: r death. ector: After this certification the funeral director, I	atic	2 ☐ Accident Investigation	on	,,		Yes 2 □ No				
Division or Vital Record	or Attendate death Director: in by the	Certification:	3 Suicide 6 Could not 4 Homicide determined		y - At home, farm, str (Specify)	reet, factory, office		28f. Location (Str. City or Town,		Number or Rui	al Route Number,
	urs af		2 2 1/2				- 1				
	e Hospital or Attending Physician: The 24 hours after death. e Funeral Director: After this certificate hi letely filled in by the funeral director, page	dical	29a. Certifier (Check only one) (Check only one)	Physician: To the best of aminer: On the basis of and manner state	examination and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) a ite and p	nd manner as s lace, and due	stated. to the cause(s)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DS MITCHELL 31. Date filed (Month, Day, Year)

FEB 0 1 2008

2001 MEDICAL PARILLANI, ANNATOLIS MO 2140 32. Registrar's Signature

State Registrar 29c. License number

D35037

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1604 Martha Court, Bel Air, Maryland 21015

21093

TIMONIUM

with the Maryland ns 23a or 3 must be n filed within 72 hours after 0 "natural" than the permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau
once.

21215-0036

Maryland

Baltimore.

9:05

Physician

/Medical

Examiner

10a. State

Funeral

Director

r 28a-f show notified at

Director

Funeral

þ

Completed

Be

ဂ္

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

20a. Method of Disposition

<u> Leslie A. Driver / Sister</u>

1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrar's Signature

The state of

TARIO MAHMOOD, M.D.

31. Date filed (Month, Day, Year)

FEB

Physician /Medical Examiner

The law requires that the death certificate be executed attending physician Physician: this Phospital or Attending Post hours after death.
Funeral Director: After the After 1

Division or Vital Records, P.O. Box 68760,

LIEDEL

Bel Air Memorial Grdn 1-29-08 Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signatu/e of Funeral Service Licensee Stocke al. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final disease or condition resulting in death) OVARIAN CANCER Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2**X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospice 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08

20b. Place of Disposition (Name of cemetery, crematory or other place)

DHMH 17 Rev 1/2001

To the Hospital within 24 hours at To the Funeral E

completely

10

Registrar

State

2300 DULANEY VALLEY ROAD

8-00716		Please Type or Print in Black Indelible I	nk. Ensure All Copies	s Are Legible.
loseph Christoph	ner N			giene 2000 02631
	_	1- For State Certificate Of Registrar		Reg. No. 2000 0200
Physicia		Decedent's Name (First, Middle,Last) Joseph Christopher McNei	11, Jr. 2	2. Date of Death Month Day Year 1.040 bro
Medical Examir		Joseph Christopher MCNZ	,] _	January 26, 2008
13			4b. City, Town, or Location of Death	4c. County of Death
1		St. Agnes Hospital	Baltimore	I NA
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral			Months Days Hours Min.	Foreign
Director	ı,	216-62-0905 1VM 2 F 53 Yrs	5.	11 01 1954 Country) NC
		Usual Residence of Decedent		10d. Inside City Limits
, any	ı	10a. State 10b. County 10c. City, Town or Loca		1 Yes 2 No
nd show	닐	MD NA Baltin	nore	
CPS ne Maryland or 28a-f show fied at once.	헣	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Fied 2	Ä۱	301 Kingston Road	21229	USA
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nen of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital etatus 12. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? (Spe	ecify Yes or No- 14. Race - American Indian, Black,
th w	ē	1 Never Married 2 Married Armed Forces? If	Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)
r dea or it	킖	1 Yes 2 No	Yes 2 No specify:	Specify: Black
afte	<u>a</u>	or Dates:	nt's Usual Occupation (Give kind of w	
nours Lxam	pg	15. Decedent's Education (Specify only highest grade completed) 16a. Decede during r	nost of working life. DO NOT use retir	
6	et	Elementary/Secondary (0-12) College (1-4 or 5+)	Law Clerk	U.S. Arny
036 rithin 72 ene. er than	Completed	Syrs		(First, Middle, Maiden Surname)
5-0 ed w dygie othe	ပိ	17. Father's Name (First, Middle, Last)		
21215-0036 hould be filed within 7 and Mental Hygiene. is marked other than tite event, the Medica	Be	Joseph C. MCNeill S2	Inarg	Carter Rural Route Number, City or Town, State, Zip Code) 21133
D 2121 should be fi and Mental 7 is marked	유		ng Address (Street and Number or R	Rural Route Number, City or Town, State, Zip Code) 21133
re, MD 2121 s 1 and 2 should be fi f Health and Mental If item 27 is marked	i l	1 tatrice lawlor 1412	o Tiverton F	Date 20c. Location - City or Town, State
and and fealth	- 1	20a. Method of Disposition 20b. Place of Disposition		Date 20c. Location - City or Town, State
Ore ges 1 of F		1 Deurial 2 Cremation 3 Removal from State crematory or c	orner place)	11/2000 Durace mills MD
Baltimore, MD pernit. Pages 1 and 2 shv Department of Health and Important: If item 27 is injury or other traumat	- [4 Donation 5 Other Specify:	CO FOR ST ST	4 2008 Owings Mills, MD
talt rmit. epart ipor jury			Name and Address of Facility Val	Wind Chilene Lineral act
m 89 7 1		Varia Colon 18	728 LIDERTY R	Randalls ton my. 2113
Physician		23a. Part I. Enfer the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac of	Bottleon Charten
/Medical		Immediate Cause (Final disease a. Head Injuries with Compl	ications	Death
kaminer		or condition resulting in death) Due to (or as a consequence of):	TOTAL TOTAL	
2"		b.		
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated		
ny e e	xar	events resulting in death) Last Due to (or as a consequence of):		
executed an and al - transit	<u>=</u>	d		
6 k=1	lical		TT 23a,27,28a-f per M	E g878 4/4/08 amh
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be ex After this certificate has been signed by the attending physician tuneral director, page 2 should be detached for use as the burial	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
87 tiffca ng pl	Į/u	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregna	ancy Month Day Year
x 6 h cer tendi	icia	4 Pregnant at time of death 5	Other (Specify)	
Bo; deatl he att	ıysi	1 Yes 2 No 9 Unknown		(1,-110
D. I t the by tl ache			e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
P.O.	by			1 Yes 2 No 3 Probably 4 V Unknown
IS, quire en si alld b	Completed			24a. Was an 24b. Were autopsy findings available
Division of Vital Records, Ital artectords, and or Attending Physician: The law require and arter death. For Director, Alter this certificate has been sitted in by the funeral director, page 2 should it.	ᇛ			autopsy prior to completion of cause of
ec he la age 2				1 ✓ Yes 2 No 1 ✓ Yes 2 No
n: T			26.Place of Death (Check	conly one)
lita sicia is cer irect	a		ent 3 DOA Other Nursi	ing Home 5 Residence 6 Other:
Phy er th	유		of Injury 28c. Injury at Work?	28d. Describe how injury occurred
	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending 2002	1 Yes 2 X No	Cohinet fall at home
sio tten death death ctor:	ertification:	2 X Accident Investigation 2002 Link		Subject fell at home 28f. Location (Street and Number or Rural Route Number, City
ViS or A Ore Dire	≝	2 Active it investigation 28e. Place of Injury - At home, farm, st	reet, factory, office building, etc.	or Town, State) 301 Kingston Rd., Balto, M
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be, within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicist completely filled in by the funeral director, page 2 should be detached for use as the burit	Cert			
Hos 24 hc Fun tely			curred at the time, date and place, an	nd due to the cause(s) and manner as stated.
the the mple	ij	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated.	gation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)
To To	Medical	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	_	11 1111	O.C.M.E.	January 27, 2008
		1 Keodon W. Ko & Thy und		
Ø		30. Name and address of person who completed dause of death (Item 23a)	111 Penn Street, Baltimo	ore MD 21201
N		Theodore M. King, Jr., MD. Assistant Medical Examiner		NO, WID 21201
	tate		80	
Regis	strai	FEB 0 1 2008		
		the state of the s		

Amend #1, 4a, per/ID, g8/6, 2/20/08 TT State of Maryland / Department of Health and Mental Hygiene For State Amend #2, perMD, #8 perFH, g876, 2/1/08 entificate of Death Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day 2008 Year Mary Josephine Martelle **Physician** 24 2008-01 4:15 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Meadows Retirement Community **Baltimore** Glen Arm If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth 9/17/19089. Birthplace (State or Foreign (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🖾 F MD Director 217-05-6706 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medicul Exemples. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 21 No Director Baltimore Nottingham 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number USA 21236 4321 Penn Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify: þ 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hair Salon 8 Beautician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emilio Morisi ဂ Louisa Brunetti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carolee Martelle/Daughter 4321 Penn Ave. Nottingham MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD 01/28/08 Joseph Cemetery 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 Diane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) endandus **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Living Home 5 Residence 6 Other (Specify) 2 this 27. Manner of Death 1 [[Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification; 5 Pending investigation 2 No death. 1 Tes 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Ballimore Ma 2/204 who completed cause of death (Item 23a) (Type, Print) 6 6701 VN Cherry 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY DE 1, EURB 9:20A **Physician** Edward Drueding Maguire /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 3/15/1948 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1₩ 2□F 220-46-5121 59 Balt., Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show the notified at 10a State 10b. County 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Timonium the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with item of Health and Mentel Hygiene.
ant: If item 27 15 marked other than "natural", or items 23a or: ury or other traumatic event, the Medical Examiner must be an ury or other traumatic event, the Medical Examiner must be a United States 9 Tintern Court 21093 America Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √2 No Specify: white 2 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Consultant Telecommunications 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Charles Maguire Elizabeth Helen McCarthy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Helen T. Maguire/ sister 32 Wesmond Drive Alexandria, Virginia 22305 20b. Place of Disposition (Name of cemetery, crematory or other p Evans Funeral 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1, 2008 Forest Hill, Maryland Chapel- Rel Air Funral Service License 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A. Timonium, Maryland 21093 2325 York Road 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ANOXIC ENCEPHALOPATHY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as the burial-transi and Due to (or as a consequence of) P.O. Box 68760, attending physician certificate be Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ► 2 ► 1 24a. Was an page 2 autopsy performe 2X No this certificate 25. Was case referred to medica examiner? funeral director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident al or Attend s after death. the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled Hospital 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DØØ17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 7601 OSLER DRIVE, TOWSON. MARYLAND 21204 HELOU M. D. . ABDALLAH J. 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 31, 9:44 A.M Patricia E. Mills January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 114 Church Road Owings Mills 8. Date of Birth (Month, Day, Year)
Mar • 27 , 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Social Security Number **Funeral** Days Hours 1 □ M 2**XX**F 82 1925 Maryland Director 219-16-9298 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2XXNo must be notified Director Owings Mills Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? United States 10e. Street and Number ō 21117 114 Church Road of America or items 23a death y Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 7 is marked other than "natural", or iten traumatic event, the Medical Examiner 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo Baltimore, Maryland 21215-0036 Specify: White þ ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; if item 27 is marked other than "n any injury or other traumatic excess." Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ola Rowzee Clarence Joseph Moran ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 85 West Sunshine Way, Westminster, Maryland 21157 Frank H. Mills, III (Son) 20b. Place of Disposition (Name of Garrills Offer Forester place) Veterans Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Feb. 5 XBurial 2 □ Cremation 3 □ Removal from State 2008 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundamental Ligens 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. Mau 11605 Reisterstown Road, Owings Mills, MD 21117 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the node of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Im neg ate Cause (Final dis e or condition resulting in death) **Physician** /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or Examiner burial-transi and Due to (or as a consequence of): Box 68760, physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year ξ 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 2 No 3 Probably 4 Nnknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2: autopsy performe 1 Yes 2 2K No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 ☐ Medical Exap On the basis of examin ation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification License number 30. Name and address of gerson who completed se of death (em 23a) (Type, Print) Al 7600 4man KKRac 31. Date filed (Month, Day, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For amend #8 Per FH G879 5/30/08 Left Edition of Department of Health and Mental Hygiene 2 0 8 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 200 Morrison Hayfa /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hopkins Dali more Johns 8. Date of Birth (Many Day, Year) 9. Birthplace (State or Foreign If Under 1 Year Social Security Number (In yrs. last birthday) **Funeral** 1□M 2**⊠**F ΜD Director 218.79.238<u>4</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County la or 28a-f show t be notified at 1 ☐ Yes 2 No Pikesville Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21208 rai", or items 23a Examiner must b 726 Leafy Terrace Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

33art: if fleam 27 is marked other than "natural", or items 23 ury or other traumatic event, the Medical Examiner must 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 → No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ₩No Baltimore, Maryland 21215-0036 Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Illzar Bhin Rhadyd Muriel Morrison ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 726 Leafydale Terrace, Baltimore, MD 21208 Muriel Morrison/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, MD Chesapeake Crem. 01.30.08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA Stephen D. Lohrmann, P.A. M01443 8717 Green Pastures Dr. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary months **Physician** disease or condition resulting in death) /Medical Examiner 4 months 100 plasia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ospital or Attending Physician: The law requires that the death certificate be executed hours after death.

uneral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ congenital hypothyroidism 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed tract infection 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Gram negatite urinary performe death? 1 ☐ Yes ventricular hend Fui Ture 2 No 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 22, 2008 DO056568 30. Name and address of per on who completed cause of death (Item 23a) (Type, Print) William Christopher Golden, 600 North Wolfe Street, Baltimore, Maryland 21287 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar A STATE OF THE PARTY OF THE PAR

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	State of Maryland / Department of Health and M 1- For State Registrar Certificate of Death						Reg. No. 2008 02641								
		Decedent's Name (First, Middle, Last)					2. Date of Month					21/	Year	3. Time of Death	
Physicia /Medic		Jo Seminaris Mullin								Jan.	29,2008 Year 8:49 P M				М
Examin		4a. Facility Name (I	f not institution, g	ive street and number)			4b. City, Town, or	Location o	of Death				of Death		
	1	Gilchrist Hospice Center				loo t hirthdou	Towson If Under 1 Year	If Under	24 Hre	9 Date of Pin		alti	more		ian
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. It				as <i>t birtrid</i> a) Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) PA			intry) PA	gn	
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how thow	_	10a. State	10b. County			, Town or L								10d. Inside City Limit	
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with the	Dir	10e. Street and Nu					10f. Zip Code 21210					A.	What Cou	intry?	
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fter d	Fun		ried 2 Married	Armed Forces?			. Was Decedent of Hi If Yes, specify Cuba			Rican, etc.)			ck, White		
urs a al', ol Exam	þ	3 ₩idowed	₩idowed 4 Divorced If Yes, Give Year or Dates:				1 ☐ Yes 2 ☑ Yo	Specify:			Specify: White				
72 ho	Completed	(Spec	15. Decedent's cify only highest of	Education grade completed)		(Giv	edent's Usual Occup	durina mos	t of worki	ng	16b.	Kind of B	usiness/l	ndustry	
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d be fental l	Be	Joseph_S								inaris	, maiden damane,				
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	ᅀ	19a. Informant's N				19b. Mai	ling Address (Street				er, City	or Town	, State, Z	ip Code)	
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Pag ment ant: i			5 ☐ Other (Spe		Che		ike Cremat		01.3				.11e,		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signarture of Fu	uneral Service Lic	censee W	1014	43	22. Name and Addres 3717 Green	ss of Facilit Past	^{ty} Crea	maion <i>A</i> Dr. Ba	And alto	Fune	ral D	Alternativ	ves
100		23a. Part1. Emer t	the disease, or co	emplications that caused ally one cause on each li	the death									Approximate Interval Between	
Physician		Immediate Cause	(Final				of dem							Onset and Death	
/Medical		resulting in death)	4	Due to (or as			0, 0, ,		/					7003	
Examiner		Sequentially list co	enditions.	b											
pe dist	Examiner	Sequentially list concause. Enter Under Cause (Disease or	erlying	Due to or as	a consequ	uence of									
e executed ian and urial-transit	xan	that initiated events resulting in death)	S 🔚	c Due to (or as	a consequ	uence of):									
e be ex sician buria				d											
death certificate be attending physici d for use as the bu	Physician/Medical												ĺ		
th cer tendir r use	an/N	IF FEMALE: 23b. Was deceden		23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy	,					ate of deli	ivery Day Year	3
e dea the at red fo	sici						5 ☐ Other (specify)					Month Day Year			
that the	Ph			s contributing to death b	out not resi	ulting in the	underlying cause give	lying cause given in Part I. 23e. Did				tobacco use contribute to the cause of death?			
Attending Physician: The law requires that the death certificate be executed reath. retath certificate he secuted ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	d by												☐ Yes 2 No 3 Probably 4 ☐ Unknown		
aw red s beer s shou	lete									24a. Was		24b.	Were au	topsy findings availat	ble
sician: The law certificate has be irector, page 2 s	Completed									auto perfe 1⊟ Yes	opsy ormed? 2 2		death?	completion of cause of 2 □ No	ΤC
ctor, p	Be C	25. Was case reference examiner?	rred to medical					26. Place	e of Death	(Check only	-				
hysic this ce	P	1 ☐ Yes 2 🛛		Hospital: 1 Inpati		ER/Outpati		4 🗆 NU		me 5□Res				city) NUSPIG	
Jing F	ioi	27. Manner of Deal	tn 5 □ Pending investigat	28a. Date of Inju (Month, Da	ay Year)	28b. Time Injury	Wor	yat k? Yes 2 □		28d. Describe	now inj	jury occu	rrea		
Attend death ctor: y the	ficat	2 ☐ Accident 3 ☐ Suicide	6 Could not	be 28e. Place of in	ury - At ho	ome, farm, s	street, factory, office	100 20					ber or Ru	ıral Route Number,	
al or / s after il Dire	Certification:	4 Homicide	determin	building, e	tc. (Specif	y)				City or To	own, Sta	ate)			
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one)		Physician: To the best caminer: On the basis of and manner st	of examina										
To the within To the comp	M	29b. Signatu Gano	title of certifier	2.40			29c. Licens	se number	70. 3		29d. E	Date sign	ed (Mont	h, Day, Year)	
		> X-4-1)			D	500	کیں		Jan	vere	1 30	anc C	
3		Arane	2 F Z	no completed cause of o		23a) (Type	OIN. U	narte:	12 2	- TONS	50.N	mo	21	204	
Sta Registr		31. Date filed (Mor	EB 0 1 2	008 32. Regist	rar's Signa	ture									

Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

> State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

MATHUR 31. Date filed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32, Registrar's Signature

and manner stated.

9106 Philadelphia Rd Ste 106 Baltimore, MD 21237

29c. License number

D0057021

29d. Date signed (Month, Day, Year)

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 1 2 5 1 3			
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tiffie of Death			
	/Medic Examir	cal	Michael W. March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, pr Location of Death			
			SINAI HOSPITAL OF BALTIMORE BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign			
ľ	Funeral Director		212-48-2178 12 M 2 F 59 Yrs. Months Days Hours Min. Matrch 21 1948 Maryland			
	yland how at		Usual Residence of Decedent 10a. State			
	the Mar 28a-f s notified	recto	MD Baltimore Middle River 1 □ Yes 2 ☒No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?			
	ath with 23a or ust be	ral Di	1313 Gunpowder Crossing Lane 21220 USA			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiptry or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1			
21215-0036	/ithin 72 ho ne. han "natur e Medical I	To Be Completed	Be Completed	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) Disabled 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled	
	ld be filed v lental Hygie ked other t ic event, th				Be	12th DISADIEU 17. Father's Name (First, Middle, Last) John William March Jr. 18. Mother's Name (First, Middle, Maiden Surname) Mary Janowhich
, Maryland	and 2 shou ealth and M n 27 is mar ier traumat					19a. Informant's Name/Relationship (Type. Print) April White /sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1313 Gunpowder Crossing Lane Balto. MD
Baltimore,	Pages 1 tment of He tant: If iten jury or oth		20a. Method of Disposition 1 Burial 2 Deremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory 1/31/08 20c. Location - City or Town, State Bayview Crematory			
Ba	permit Depar Impor any In		21. Signature Funeral Service Dense 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221			
			23a. Perry Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final			
	Physician /Medical		disease or condition resulting in death)			
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):			
Y	is that the death certificate be executed ted by the attending physician and detached for use as the burial-transit.	Examiner	that initiated events resulting in death) Last c. Due to bras a consequence of:			
68760,		dical E	5 small bowel ischemia 8 days			
.O. Box 6		by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 nonths? 1 Yes 2 UNo 9 Unknown Unknown Unknown 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year Yea			
ords, P	The law requires that the ate has been signed by the bage 2 should be detache		b	þ	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division or Vital Records,		Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No			
r Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes			
o uo	ding Ph h. After thi funeral	tion: T	27. Manner of Death 1			
Divisi	al or Attending s after death. Il Director: After d in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attending Prwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 American Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	With Con	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3anuary 29, 2008			
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harianna J. Jackson, M. D. Sinai Hospital of Battimore 31. Date filed (Month, Day, Year), 2008 32. Registrar's Signature			
	Sta Regist		31. Date filed (Month, Day, Year) 2008 32 (Registrar's Signature)			

		1 - For State Registrar	State of Marylan		ent of Health ar ate of Death		giene2 () () { Reg. No.	02644		
Physi		1. Decedent's Name (First, Middle, Last)	Millsth	prnto	\cap	2. Date of Dea Month		3. Time of Death 8 10:10fM		
/Med Exam		4a. Facility Name (If not institution, give a SAM AR)	street and number)	4b. Ci	ty, Town, or Location of		4c. County of Dea			
Funera Directo	_	5. Social Security Number 6. Sept 214-12-0483	7. Age (In yrs. I	last birthday) If Und Month	der 1 Year If Under 24	8. Date of Birt Min. (Month, Day Jan 15		thplace (State or Foreign ountry) yland		
anyland •how	2	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Location				10d. Inside City Limits 1		
or 28a-1	Directo	MD 10e. Street and Number		Baltimore 106.	Zip Code		10g. Citizen of What Co			
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after deeth with the Maryland t Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-1 ehow other traumatic event, the Medical Expanding rough by multiling at	Funeral Director	1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1	If Yes, s	21214 Dedent of Hispanic Original Control Cuban, Mexican, 1 2 ■ No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	USA 14. Race - Ame Black, Whit Specify: b1	e, etc.		
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental hygiene. 7 is marked other than "natural; or traumatic event, the Medical Expu	Completed by	15. Decedent's Edu (Specify only highest grade	Year or Dates: ication le completed)	16a. Decedent's U	sual Occupation	of working	16b. Kind of Business			
d 212 filed with Hygiene. other than	e Com	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	poet/wi		s Name (First, Middle,	journalism	l		
arylan should be ind Mental i marked o	To Be	Frank Lewis 19a. Informant's Name/Relationship (Ty.	one Crist)	10h Mailia - Adda	Ger	maine Franl	klin			
Page Page mento		Susan Brown/god d 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 ☒ Donation 5 □ Other (Specify)	aughter Removal from State	P.O. Box lace of Disposition (A emetery, crematory o	47183 Balt		er, City or Town, State, 2 21244 20c. Location - City or			
Baltimo permit. Pages Depertment of Important: If i		21. Signatura Launeral Service Licenses	11/1000	Baltin	more, MD 2	1201	Baltimore	Street		
BY60, ale be executed Wedica Examine Thysicien and the burial-transit	I	23a. Pan 1. Enter the disease of composition or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ASCYD	vence of):	ode of dying, such as ca	ardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death		
Geath certifice attending point for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	.3c. If yes, outcome of pregna 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic			23d. Date of de Month	ivery Day Year		
£ 28	र्व	Part II. Other significant conditions con		id tobacco use contribute to the cause of death?						
The The page	Completed		rmed? prior to death?							
VITAL F sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	locaital:			ath Check only or	nel			
Phys this	5	1 Yes 2 No		ER/Outpatient 3 [] [lence 6 Other (Spe	city)		
LIVISION of attending later death. Director: After tin by the funer	cation	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At ho	y Year) 28b. Time of 1 28c. Injury at Work? 1 □ Yes 2 □ No			28d. Describe how injury occurred			
0 = -	Certification;	4 Homicide determined	City or Tow							
he Hospital or n 24 hours aft he Funerai Di pletely filled in	Medical	29a. Certifier (Check only one) Certifying Physical Certifical C	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occurre ion and/or investigation	ed at the time, date and in the control of the cont	place, and due to the o occurred at the time, o	cause(s) and manner as date and place, and due	s stated. to the cause(s)		
To the t within 2. To the complet	Σ	29b. Signature and title of certifier	D	r	9c. License number	\sim	29d. Date signed (Mont	*		
		30. Name and address of person who co	employed cause of death (Item	23a) (Type, Print)	Valtonin	nevor	bal	n D 2 1234		
S: Regis	tate	31. Date filed (Month, Day, Year) FFB 0 1 200	32 Registrar's Signat		3			(

Division or Vital Records, P.O. Box 68760,		Baltimore, Maryla
he Hospital or Attending Physician: The law requires that the death certificate be executed	Phy /M Ex	permit. Pages 1 and 2 should
the Funeral Director: After this certificate has been signed by the attending physician and		Important: If item 27 is marke
pletely tilled in by the tuneral director, page 2 spould be detached for use as the burial-transit		any mility or other fraumatic

	1 - For State Registrar	Cei	rtificate of Death	Reg.							
ian	1. Decedent's Name (First, Middle, Last) HARRY MCALLIST	ER		and the second s	Day Year 3. Time of Death 7/97						
1161	4a. Facility Name (If not institution, give street and number Mercy Medical Con	"	4b. City, Town, or Location of Deat Baltone If Under 1 Year If Under 24 Hrs	i. 8 Date of Birth	4c. County of Death 9. Birthplace (State or Fore						
	215-85-9930	44 Yrs.	Months Days Hours Min	Jan 7, 19							
	10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Lim						
Director	MD	Baltimo		1√ Yes 2 No 10g. Citizen of What Country?							
l Dire	10e. Street and Number 601 S. Charles Street		10f. Zip Code 21230	10g.	USA						
by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Deceder Armed Forces 1 □ Yes 2 2 If Yes, Give Year or Dates	No	Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puel 1 ☐ Yes 2 ☒ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White						
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4o	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) plumber		16b. Kind of Business/Industry unk						
Be C	17. Father's Name (First, Middle, Last)			me (First, Middle, Maid	den Surname) ui						
2	19a. Informant's Name/Relationship (Type. Print)	19h Maili	ng Address (Street and Number or F	Rural Route Number Ci	by or Town State Zin Code)						
	Paulette McAllister/spou		.2 Paul martin Dr								
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☒ Other (Specify) in Stat	e	osition (Name of matory or other place)	Date 20c	Location - City or Town, State						
	21. Signature of Eneral Stylice Sciences and Address of Facility Board 655 W. Baltim Baltimore, MD 21201										
		ed the death. Do not en	ter the mode of dying, such as cardia		Approximate Interval Between Onset and Death						
	resulting in death) Due to (or as a consequence it):										
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
Physician/Med		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year						
b	Part II. Other significant conditions contributing to death	but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No ③□ Probably 4 □ Unknow							
Completed				24a. Was an autopsy performed							
o Be	25. Was case referred to medical examiner? ↑★ Yes 2 No Hospital: 1 □ Inpa	itient 25ER/Outpatie	Other:	eath (Check only one)	C TOMber (Creek)						
-1	27. Manner of Death †★Natural 5 Pending 2 Accident investigation			28d. Describe how i	e 6 Other (Specify) njury occurred						
Certification:	4 Homicide determined building,	njury - At home, farm, st etc. (Specify)		City or Town, S							
ca	29a. Certifier (Check only one) Certifying Physician: To the best and manner Check only one)	of examination and/or in									
Ö	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yea										
Medical	29b. Signature and title of certifier				mack, MD						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** ANUAR 2008 28 HAROLD IRVIN MASTER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BELAIR Harford MARINER HEALTH IN BELAIR 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**X** M 2 □ F Director 216-16-8372 83 May 17, 1924 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Harford Bel Air 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1704 Gatehouse Ct. 21014 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1√ Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Landscaping Equipment Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Raymond Thomas Master Edith Blessing Barnitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth B. Master / Wife 1704 Gatehouse Ct., Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp 1-29-08 Towson, Maryland 21. Signature of Functial Service Lucen 22. Name and Address of Facility
McComas Funeral Home, McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** emen er /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a detached f 9 Unknown page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed2 ce rtificate 1∐ Yes 2 No 25. Was case referred to m a al examiner? funeral director, 26. Place of D ath Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3□ DOA ဥ After this 28a. Date of Injury (Month, Day Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 atural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ö 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 hert A Duch

State Registrar

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7008 Dav 5:20 am arolun January 4a. Facility Name (If not institution, give street and number 4c. County of Death Bultimore HOOKINS Hospital Johns CIT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 5, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 □ F 1946 Pennsylvania Oct. 196-38-1755 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Edgewood Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21040 USA 3907 Walters Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Orlando (unk) Deflice Lucy (UNK) (UNK) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3907 Walters Rd., Edgewood, MD 21040 Steven C. Siler / Companion 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdn: 2-1-08 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. Telle 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Stage Immediate Cause (Final disease or condition resulting in death) IV breast concer with systemic metasteris months Due to (or as a consequence of) currens bacteremia Methesiline susceptible Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury

Physician /Medical **Examiner** Examiner

Physician

/Medical

Examiner

Director

Funeral

Ş Q

Completed

Be

Funeral

Director

show r 28a-f show notified at

ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If frem 27 is marked other the any injury or other traumatic.

Maryland 21215-0036

Baltimore,

physician the

Physician/Medical Completed certificate this Certification: After t al or Attending Patter death.

the

filled in by

Medical

within 24 hours at To the Funeral C completely filled i Hospital

the

23b. Was decedent pregnant

27. Manner of Death 2 Accident 3 Suicide

4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) January

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bath North 600 Jonathan

Street, Baltimore Wolfe

State Registrar 31. Date filed (Month, Day, Year) 0 1 2008 FEB



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Mackall 1/25/08 8:30 PM Leroy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA Genesis Lochraven Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 3/30/41 9. Birthplace (State or Foreign Country)
MD Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Min. 1 □ **M** 2 □ F Yrs 22<u>0-38-65</u>38 **Director** 66 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 Nes 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 21040 Funeral 613 Otter Creek Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No þ Specify. 3 Widowed 4 Divorced Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ealth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 7thGrade NA Maintenance NA or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mackall Aurelia ျှ Leroy Stanley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is:
any Injury or other free... Lisa MAckall-Conigland 613 Otter Creek Rd. Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/30/08 Greenmount Baltimore, MD Cem 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H East Bemand Bernard D Harris 1101 East North Ave Bal 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 East North Ave Baltimore, MD21202 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** year /Medical Due to (or as a consequence of): Examiner 20 Vascu Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed 201 burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 2 No page 2 s certificate has 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Ygar) 29c. License number, 29b. Signature and title of cerffier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box 68760,

P.0.

Division or Vital Records,

State Registrar 31. Date filed (Month, Day, Year) FEB 0 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00701 State of Maryland / Department of Health and Mental Hygiene 2008 02649 Sidney Roland Millner, III Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 26, 2008 1345 hrs Medical Examiner Millner Roland Sidney c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore University of Maryland Medical Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Country) Months Days Hours Min Director 217-13-7403 MD 1 XM 2 25 /82 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 XYes 2 No s 23a or 28a-f show a notified at once. Baltimore MD NA Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21223 1002 Bennett 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. it: If item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner must be nother traumatic event, White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Married Never Married Yes Specify: Black Yes 2 X No specify: If Yes, Give Year 3 Widowed Divorced ò 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours: Department of Health and Mental Hygiene. pleted during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) NA Student College 12th Grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Angela White Sidnev R. Millner Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1002 Bennett Pl. Baltimore, Md 21223 Sidney R.Millner Jr.Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Baltimore, MD 2/1/08 Donation 5 Other Specify Trinity 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H East 21202 1101 East North Ave Baltimore, MD may CHANANA Approximate Interval 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Death Modical a. Multiple Gunshot Wounds Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) If any, leading to immediate Examiner Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician for use as the burial -Box 68760, 23d, Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Yes 2 ✓ No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? certificate has No 1 🗸 Yes 2 ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 🗸 Inpatient 2 Residence 6 Other: Nursing Home 5 FR/Outpatient 3 DOA this 1 V Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury After 27. Manner of Death Subject shot Certification: Jan 24, 2008 1736 hrs Yes 2 V No Natural Pending Director: hin 24 hours after death the Funeral Director: 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 or Town, State) 1154 N. Stricker Street, Baltimore, MD Suicide determined (Specify) Store 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E January 28, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Patricia Aronica-Pollak MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year, State FEB Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 1:35 P.M Mabel Lee Nowlin January 31, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Center Randallstown **Baltimore** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Mar. 14, 19 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Maryland 218-10-8630 86 Mar. 1921 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 TYYes 2 □ No notified Director Sykesville Maryland Carroll 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò traumatic event, the Medical Examiner must be 21784 7309 Second Ave. U.S.A. or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 🕻 No Specify: White þ 3 Widowed 4 ☐ Divorced 'natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Waitress 6 Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Levi Filbert Gertrude Struder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any Injury or other trau 4 Orchard Place, Sykesville, Md. 21784 Howard W. Jones - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem. Feb. 8,2008 Owings Mills, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility

Eckhardt Funeral Chapel, P.A.,
Owings Mills, Md. 21117 any In 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ticemic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or us a consequence of): Examiner requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): burialphysician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? (es 2 No certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: the Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Within 24 hours after To the Funeral Direct 4 🗌 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO061886 Somony 31, 2008 son wir completed cause of death (Item 23a) (Type, Print) Randalls tough, 30. Name and address of 324 Registrar's Signation Benjamina Year) 31. Date filed (Month, Day, State FEB 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 100 and famor Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month William Stanley Polinsky 30. 2008 January 5:40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 040-44-6324 1 ☑ M 2 □ F 58 Yrs. 8/29/1949 Connecticut Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Timonium 1 ☐ Yes 2 ☐ No Maryland Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 8C Quiet Stream Court 21093 America 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Technology Sales Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stanley Polinsky Dorothy Sinnamon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Polinsky/ wife 1 D. Wind Mill Chase Sparks, Maryland 21152 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery crematory or other place)
Evans Funeral
Chapel - Bel Air 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State January 31, 2008 Forest Hill, Maryland Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Du to (or as a consequence of): disease or condition resulting in death) oconasu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 21 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ 100 autopsy performed? 2 100 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 *Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Examiner ng physician and as the burial-transit Division or Vital Records, P.O. Box 68760 attending p page 2 s within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

Completed by Physician/Medical

Be

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Medical Certification:

Physician

/Medical

Examiner

Funeral

Director

'natural", or items 23a or 28a-f show dical Examiner must be notified at

21215-0036

Baltimore, Maryland

1 and 2 should be filed within 72 Health and Mental Hygiene.

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Many June.

Physician

/Medical

Funeral

Completed

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

FEB 0 1 2008

Cyntha Smiano No



29c. License number

DOOS1347

29d. Date signed (Month, Day, Year)

1/30/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Pennington 045 AM thaniel 23 la James 3008 /Medical January 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner 177 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1 X M 2 □ F Hours Min. Yrs 213-65-1848 5 August 8, 2002 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Director Baltimore 1XX Yes 2 □ No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 3411 Brendan Ave. 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christopher J. Pennington Amanda Spearman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda Spearman- Mother 3411 Brendan Ave., Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Memorial Park! Jan. 30,2008 Elkridge, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fleck Funeral Home, 21. Signature of Furleral Service Licensee INC. Mh m0/234 7601 Sandy Spring Rd., Laurel. Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner y Der Kalemi Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): the aftending physician Physician/Medical as the b IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Lung 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No ydro cephali 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760, e Funeral Direc

within 24

Baltimore, Maryland 21215-0036

Medical

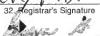
State

31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

Michae



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Certificate of Death

If Under 1 Year

Days

7. Age (In yrs. last birthday)

Yrs.

4b. City, Town, or Location of Death

<u>Kensington</u>

Hours

Director July 11, Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at Directo Maryland Montgomery <u>Kensington</u> 10e. Street and Number 10f. Zip Code 4220 McCain Court 20895 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ₩ Widowed 4 □ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Employment Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter S. Mantis 19a, Informant's Name/Relationship (Type, Print) Georgia Coffey / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition February 2, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2008 Glenwood Cemetery 21. Signature of Funeral Service Licerses M01473 23a. Part1. Enter the disease shock, or heart failure. I complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrythmia /Medical Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine for use as the burial-tran Hyperlipidemia Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical Hypertension IF FFMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 1 ☐ Live birth 2 Fetal death 3 □ Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 Completed 24a. Was an autopsy 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No 2 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral C 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1201

32. Registrar's Signature

Patricia Kellogg, M.D.

31. Date filed (Month, Day, Year) FEB 0 1

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

577-42-1853

Archontoula Papadopoulos

4a. Facility Name (If not institution, give street and number)

4220 McCain Court

1 □ M 2**X** F

6. Sex

Physician

/Medical

Examiner

Funeral

State Registrar

State of Maryland / Department of Health and Mental Hygiene

2. Date of Death

10:25PM M 2008

Month Year 29, January

4c. County of Death

Montgomery 8. Date of Birth (Month, Day, Year)

Birthplace (State or Foreign Country)

1930 Washington D.C.

1 ☐ Yes 2 X No

10g. Citizen of What Country?

<u>United States</u> Black, White, etc.

> Specify White

16b. Kind of Business/Industry

Capital Hilton Hotel

Argyro Papakonstantinou

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14038 Weeping Cherry Drive, Rockville, MD 20850

20c. Location - City or Town, State

Washington, D.C.

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Approximate Interval Between Onset and Death

Minutes

Years

Years

Years

23d. Date of delivery Month Day Year

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number 29d. Date signed (Month, Day, Year)

D21392

Seven Locks Road, Ste. 111, Rockville, MD 20854

January 30, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:00 PM 2008 Lillian M. Quinn 0 /Medical 4a. Eacility Name (If not institution, give street and number) 4c. County of Death Examiner Center seda if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD Date of Birth (Month, Day, 09 23 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M 2 ₽ F 93 T914 Director 216-01-5890 Usual Residence of Decedent a or 28a-f show the notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a the Medical Examiner must b 7 Silverwood Ct. by Funeral 21236 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No White Specify: 3 ₩ Widowed 4 Divorced Maryland 21215-00 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Timekeeper Bendix Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Calvert L. Ford Edna E. Cousler ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pam Savage/Daughter Silverwood Ct. Nottingham MD 21236 other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages ₽ Department of Important: If it any Injury or c 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/30/08 Dulvaney Valley Timonium 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** ocaraia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician use as t IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? for 4☐Pregnant at time of death Month Day Year 5 Other (specify) detached 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform certificate 1 2 No Yes or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 32 DOA Certification: To 1 ☐ Inpatient this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident (Month, Day Year) within 24 hours after deam.

To the Funeral Director: Aft 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated

(b) State ad title of

FEB 0

certifier

2008

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29b. Signatuk

TRIC

31. Date filed (Month, Day,

rankli-

29c. License number

Batto, MU

21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For amend #30 Per DVR G876 2/01/08 JH Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** James A. Quick 0135 2008 /Medical lanuary 25 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital

5. Social Security Number 6. Sex lalbot 8. Date of Birth (Month, Day, Year)
July 28, 1 If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday If Under Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 □ F 89 1918 Director 217-01-0585 Pennsylvania Usual Residence of Decedent 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 □Yes 2↓ No MD Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or Items 23a or in prize in jury or other traumatic event, the Medical Examiner must be repore. 21601 610 Dutchmans Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk butcher grocery store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Pages 1 and 2 should be Arthur Alexander Quick Pearl Norwood ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9510 Service Lane Easton, MD Mary Quick/spouse 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade Director State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** car /Medical Due to (or as a consequence of): **Examiner** Examiner law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician/Medical

attending physician and for use as the burial-tran been signed by the should be detached

Suick, James

cate has ; certificate

	Sequentially list conditions,	D					
Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):				
Exa	resulting in death) Last	Due to (or as a conseq	uence of):	1			
dical		d					
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	at death 3 □Ectopic	pregnancy specify)		23d. Date of de Month	elivery Day Year
Y P	Part II Other significant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute t	to the cause of death?
ed b	Sick Jenus	- Lyndron	re		1 ☐ Yes	2 □ No 3 □ F	robably 4 hknown
Complet	Sleep Op	nea mal lib	illation	M	24a. Was an autopsy performed'	prior to death?	utopsy findings available completion of cause of s 2 ☐ No
Be (25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only one)		
ဥ	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatient 3 ☐ [OOA Other: 4 Nursing H	lome 5 ☐ Residence	6 □Other (Spe	ecify)
	27. Manner of Death 1 ★ Atural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28f. Location (Street City or Town, St.	Location (Street and Number or Rural Route Number, City or Town, State)				
Medical (29a. Certifier (Check only one) Certifying Ph	nysician: To the best of my knominer: On the basis of examination and manner stated.	wledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occi	e, and due to the cause urred at the time, date	e(s) and manner a and place, and du	is stated. le to the cause(s)
ž	29b. Signature and title of certifier	1 . 1	2	9c. License number	29d. I	Date signed (Mon	ith, Day, Year)

State Registrar

Hospital or Attending Physician:

ospitar .
.4 hours after dec..
-1.uneral Director: After 24 hours a completely

within 24

31. Date filed (Month, Day, Year)

Carolyn Sué Helmlv

30. Name and address of person who completed cause of death

1

Easton, Md. 21601

tem 23a) (Type, Print)

3602

32 Registrar's Signature

				ase Type or State o				k. Ensure A Health and I			•	0005	
			1 - For State Registrar			C	ertificate of	Death		Reg. No	ZUUC	3 0265	
ėj salina	Physici /Medi		al Frederick Matchew Relinioldt Jr. 1 31 2008								3. Time of Death 11:20 A.M		
	Examir	ner	4a. Facility Name (If not institute		or Location of Death	1	40	. County of Dea					
	Funcion 1		Gilchrist 5. Social Security Number	6. Sex	7. Age (In	yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day,)				Baltin	NOTE thplace (State or Foreign	
J 2	Funeral Director		212-20-0212 Usual Residence of Decedent	Ж ХМ 2□ F	95 (82 Yrs.	Months Days		(Month, D 11/3/	1925 1925	Balt	t., Maryland	
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	th with th 23a or 24 1st be no	al Dire	10e. Street and Number 6613 Pheasant	Road			10f. Zip Code 212.	Un:	tizen of What Co ited Sta America	ates			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Ma	l If Yès. Gi	orces? 2 ☐ No ive	If Yes, specify Cuban, Mexican, Pue			pecify Yes or No o Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: W	te, etc.	
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Maryland 21215-0036	vithin 7 sne. han "n ie Medi	Be Completed	Elementary/Secondary (0-12)	est grade completed) College ((Give kind of work done during most of working life. DO NOT use retired)					•		
9	filed v Hygie other i	ပ္ပ	17. Father's Name (<i>First, Middle</i>	 , Last)		Ma	aster Mec	T	ne (First, Middle	Penn Central Railroa dle, Maiden Surname)			
an	Ald be Alental riked c	To B	Frederick	Matthew Re	einho:	ldt Sr.		Flora	ark				
ary	2 shou and 1\ is ma auma	[Frederick Matthew Reinholdt Sr. Flora Mae Clark 19a. Informant's Name/Relationship (Type. Print) Catherine E. Reinholdt/ dau. 19b. Mailing Address (Street and Number or Rural Route Number, Clark 6613 Pheasant Road Middle Riv										
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Bai	permit Depar Impor any in once,		21. Signature of Funeral Service	e Ligensee		_ E	22. Name and Addi Cacciul /	Alternativ	es Fune	eral	&Cremat	ion Ctr.,P.	
	Physician		23a. Part1. Enter the disease, on shock, or heart failure. List Immediate Cause (Final disease or condition	or complications that of the control one cause on the cause of the cau	caused the each line.	death. Do not e					Maryland	Approximate Interval Between Onset and Death WELKS	
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O. Box	The law requires that the death certificate to the law been signed by the attending physicage 2 should be detached for use as the band.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 🗆 nant at time	Fetal death	B Ectopic pregnan	су			23d. Date of de Month	livery Day Year	
<u> </u>	w requires that the d been signed by the should be detached	y Ph	Part II. Other significant condit	ions contributing to d	eath but no	t resulting in the	underlying cause g	iven in Part I.	23e. Did	tobacco	use contribute to	o the cause of death?	
Vital Records,	en sign	ed by							1 🗆	Yes 2	No 3□P	robably 4 □Unknown	
ပ္ပ	law re las be	Completed							24a. Was		24b. Were au	utopsy findings available completion of cause of	
E E		Con							perf 1□ Yes	formed? 2 No	death?		
<u> </u>	sician ; The law certificate has t irector, page 2 s	Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	1	0EEE00-t	05.004 0	26. Place of Dea				^ .	
Ö	g Phy er this eral di	J: To	27. Manner of Death	28a. Date	of Injury	2 ER/Outpati	of 28c. Inj	4 Li Nursing n	ome 5 L Res 28d. Describe			city) Maxico	
õ	ath. or: Aft	atio	Z LI Acoident	igation	nth, Day Ye	ar) Injury		Yes 2 □ No					
DIVISION	al or Atte s after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deteri	mined 28e. Place	of injury - ing, etc. (S	At home, farm, specify)	street, factory, office		28f. Location City or To	(Street ar own, State	nd Number or R e)	ural Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical (29a. Certifier (Check only one) Certify 2 Medica	ng Physician: To the I Examiner: On the b and man	e best of my asis of exa ner stated.	/ knowledge, de mination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occu	, and due to the irred at the time	e cause(s	s) and manner as ad place, and due	s stated. e to the cause(s)	
	To the withing to the complex	ž	29b. Signature and title of certifi	er A 1				ise number			ate signed (Moni	th, Day, Year)	
	N		30. Name and address of person	who completed a	no of death	(Itom 22a) /T:	2 Brint'	2000		Janu	ery 51	4008	
	12,			NWES W		(Helli 23a) (Type	harics S	58303 T POWSUM	mo	21	204		
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1.		10	Negistrar 1. Decedent's Name (First, Middle, Last)			ranoate or	Death	2. Date of D			3. Time of Death	
	Physic /Medi		Joseph S. Rider, Jr. January 3							, 2008	6:14 P M	
	Examii	ner	4a. Facility Name (If not institution, give street and no Dove House	or Location of Dea inster	th	1	4c. County of Death Carroll					
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.			If Under 24 Hr	irth		place (State or Foreign ntry) yland		
	Director		Usual Residence of Decedent	79	Yrs.		110010	May 2	3, 19	28 Mar	y1and	
	aryland show d at	1	10a. State 10b. County		ty, Town or Lo				10d. Inside City Limits			
	the Ma 28a-f	Director	MD Carroll 10e. Street and Number	We	estmi	nster 10f. Zip Code	10a Citiz	en of What Cou	1 ☐ Yes 🏋 🕅 No			
	th with 23a or 1st be	al Di	552 Houck Rd.			21	rog. Oniz	U.S.A.				
	d within 72 hours after death with the Maryland giene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	Armed F	cedent Ever in U		Was Decedent of If Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or N rto Rican, etc.)	0- 1	4. Race - Americ Black, White,		
5-0036	urs aft al", or Exami	by	1 ☐ Never Married XX Married If Yes, G 3 ☐ Widowed 4 ☐ Divorced Year or I	^{2□No} ive Kore	a	1 □ Yes XX No		Specify: White				
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and ?	e file al Hy othe vent,	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle	e, Maiden S	iden Surname)		
5	hould in marker marker	မှ	Joseph S. Rider, S	Sr.	10h Mailie	ng Addross (Stron	1	Brick		City or Town, State, Zip Code)		
Mar	and 2 salth ar 27 is er trau		Dorothy Rider / Wife	9			Rd. Wes				′	
saitimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked any injury or other traumatic eroce.		20a. Method of Disposition XX Bunial 2 □ Cremation 3 □ Removal from	State Mo	Place of Dispo	osition (Name of	ace)	Date		ation - City or To	own, State	
	artmen ortant: injury	XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Amount of Funeral Service Licensee Cemetery Cemetery 2/7/08 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Fu								wings Mills, MD		
n n	permit Depar Impor any ir		I factual for			aper P.A. .s,MD21117						
10.	Physician /Medical Examiner	je je	Due to	caused the deat each line. tasta (or as a conseq	uence of):		ing, such as cardia	. ,		mary	Approximate Interval Between Onset and Death	
08/00,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a conseq								
.O. BOX	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	in the past 12 months?	tcome pf pregna birth 2 □ Feta nant at time of d	Ideath 3□	□Ectopic pregnanc □ Other (specify) _	cy		23	23d. Date of delivery Month Day Year		
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vital nec	To the Hospital or Attending Physician: The law rathin 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sh	e Completed	25. Was case referred to medical					pert 1⊟ Yes	opsy ormed? 2 No	24b. Were auto prior to co death? 1 ☐ Yes	ppsy findings available mpletion of cause of	
_	nysicia nis cert directo	To Be	examiner?	Inpatient 2	ER/Outpatien	nt 3 DOA Ot		ath <i>(Check only</i> Home 5 ☐ Res			y) Inputient	
	ending Pt eath. or: After th he funeral		2 Accident investigation	of Injury oth, Day Year)	28b. Time of Injury	Wo	iryat irk?]Yes 2 ∐No	28d. Describe	how injury	occurred	hospice	
2	ital or Att Irs after de Iral Direct Iled in by t	Certification:	4 Homicide determined build	ing, etc. (Specify	v)	eet, factory, office		City or To	iwn, State)		al Route Number,	
	e Hosp 24 hou e Fune letely fi	Medical	29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the hand mar	e best of my kno pasis of examina Iner stated.	wledge, death tion and/or in	h occurred at the t vestigation, in my	ime, date and plac opinion, death occ	e, and due to the curred at the time	e cause(s) a , date and p	and manner as s place, and due t	tated. o the cause(s)	
	To th within To th	Me	29b. Signature and title of certifier			29c. Licen				signed (Month,	•	
			Howard Soioif, M.	₹ .			2225			131108		
	5		30. Name and address of person who completed cau Howard Saionts M. P.	se of death (Item	23a) (Type,	erint)	t. We	Stanins	ter l	md, 21	157	
ľ	Sta Registr		31. Date filed (Month, Day, Year) 32. F.E.B. 0 1 2008	Registrar's Signa	ture	Grante 1	T. We					

VOID

Karen Denise Romeo

certificate no .: 2008-02-659

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Maryland		artment of H rtificate of I		nd Men	tal Hygi Re	ene g. No. 2	008	02660	
			Decedent's Name (First, Middle, Last	st)						Date of Death		Year	3. Time of Death	
	Physicia		ELIZABETH JULI	A RILE	Y					^{Month} ANUARY	30, 2		17:22 M	
	/Medic Examin	Luke .	4a. Facility Name (If not institution, give				4b. City, Town, or Location of Death 4c. Coun				4c. Count	y of Death		
ŧ (# T		1303 Loflin Road				Aberdee				Hari			
	Funeral		5. Social Security Number 6. S	ex □ M 2. 3 kF	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 2 Hours	Min. (Date of Birth Month, Day,	Year)	Cour		
	Director		214-14-8985	LIM ZIZZI	90	Yrs.			Ju	ne 28,	1917	Mary	<i>r</i> land	
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation					1	0d. Inside City Limits	
	Maryl f sho led a	ō	Manual Hamford	1	Λh	erdeer	2						1 ∐Yes 2 XNo	
	the 128a-	Director	Maryland Harford 10e. Street and Number		AL	ETGEE	10f. Zip Code			10	g. Citizen of	What Cou	ntry?	
	n with		1303 Loflin Roa	ıd			21001							
	deatl	Funeral	11. Marital Status		dent Ever in U.	S. 13.	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. Race - American Indian, Black, White, etc.		
9	after or ite mine	/Fu	1 ☐ Never Married 2 ☐ Married	2 X No e						Spec	ify: TATH	nite		
200	ural",	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Da	ites:	160 Door	dent's Usual Occur	nation		16b. Kind of Business/Industry				
Ω.	"nati	Completed	15. Decedent's Ed (Specify only highest gra	ade completed)		(Give	kind of work done DO NOT use retire	during most	t of working	187	TOD. Talla of			
12	withir ene. than	E C	Elementary/Secondary (0-12)	College (1	-4or 5+)	Clerl	ζ.				Banki	ng		
2	be filed within 72 hours after death with the Maryland tial Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be Co	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name <i>(Fii</i>	rst, Middle, N	laiden Surna	ame)		
au		To B	John J. Berenge	r						Julia_				
ary			19a. Informant's Name/Relationship (ing Address (Street							
Σ	1 and 2 Health a em 27 is		Robert Chilcoat /	Son_			Regal Dr	rive, A						
ore	of He		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐	Removal from		Place of Disp cemetery, cre	osition (Name of ematory or other pla	ice)	Date	1	20c. Location	1 - City or I	own, State	
Ĕ	Pages ment of l ant: If ite		4 □ Donation 5 □ Other (Special	fy)	Hig	ghview	Memorial	Gard	ens 2-	4-08		ton, I	Maryland	
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heali Important: If item 2 any injury or other		21. Signature of Funeral Service Lice	nsee		1	2. Name and Addre	unera.	1 Home	P.A.		Ma7	21000	
			11/11114 /	A STORY OF A STORY OF	ausod the deat	h Do not er	1317 COKE	sbury	cardiac or re	AD110	ast.	Mary	and 21009 Approximate	
		8	23a. Part1. Enter the disease, or comshock, or heart failure. List only								,		Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)		ocar or as a conseq		INF	AYCC	TION	4		-		
in Ag	Examiner						SIDN						18 years	
4		ē	Sequentially list conditions, range leading to immediate b. Late (or as a consequence of):											
D.	uted d ansit	Examiner	Dust () as a consequence of): If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Cause (Disease or injury that initiated events)								184 ears			
O	e exectant an	EX	resulting in death) Last		or as a conseq		1 -	0-1	0.0		- · (0 - E			
8760,	the burial-transit	dical		_ dC	HROM	110	REN	AL	12156	PASE			zyears	
ဖ	ertific ling p	Mec	IF FEMALE:	ODa If you out	toomo of progo	anov					024	Data of doli	(OD)	
Box	ath o	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	tcome pf pregn pirth 2 ☐ Feta nant at time of c	al death 3	□Ectopic pregnand	су				Date of deli Month	Day Year	
o.	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unkn		Jean 5	Cirici (apociny) _							
۳.	The law requires that the death certific the las been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions	contributing to d	eath but not res	sulting in the	underlying cause gi	iven in Part I	1.	23e. Did tol	bacco use co	ontribute to	the cause of death?	
ds,	uires sign lid be	d by	Smolgin	9						1 📑 1	es 2□No	3 □ Pro	bably 4 □Unknown	
ဝ္ပ	s been shou	Completed	Carotic	i b	ruits	,				24a. Was a		b. Were au	topsy findings available ompletion of cause of	
æ	The la te has	E O	Hictor	y of	Atr	Sal	Fibr	illati	0.0	perfor	med?j	death? 1 ☐ Yes	2 ⊟ 1√0	
ita	ian: '	Be C	25. Was case referred to medical	4 -		7 62 1				Check only on	ie)			
>	nyslc nis ce direc	To E	examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpation	ent 3 LOA			5 Resid			cify)	
n 0	Attending Physician: r death. ector: After this certifics by the funeral director, I		27. Manner of Death 1. Natural 5 □ Pending		of Injury hth, Day Year)	28b. Time Injury	· We			l. Describe h	ow injury oc	currea		
Sio	tendi eath. tor: A	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not		of joinny At h	omo farm s	M 1 1 Estreet, factory, office	∏Yes 2 ☐		Location (S	treet and Ni.	ımber or Ru	ıral Route Number,	
Division or Vital Records, P.O.	or At ifter d Direct in by	Certification:	4 Homicide determined	ZOE. FIAU	ing, etc. (Speci	ify)	nieet, iactory, omoc		201	City or Tow	n, State)			
	pital ours a leral l		29a. Certifier 1 Certifying P	hysiclan: To the	e best of my kn	owledge, de	ath occurred at the	time, date a	ınd place, and	d due to the o	ause(s) and	manner as	stated.	
	e Hos 24 h e Fun letely	Medical	(Check only 2 Medical Exa	aminer: On the b	pasis of examin nner stated.	ation and/or	investigation, in my	y opinion, de	ath occurred	at the time, o	date and pla	ce, and due	to the cause(s)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Me	29b. Signature and title of certifier					nse number				1	h, Day, Year)	
			1 30 Cm	uno,	ni O		10	462	68			2/01	108	
	-61		30. Name and address of person who	o completed cau	se of death (Ite	m 23a) (Typ	e, Print)	10	2	10 . 11	00	a. i	mp, MO 210	
	10		Gwenneth		NCIA			(200)	zrass	mill	Kel 1	rsela	mp, MO 210	
	C+	ate	31. Date filed (Month, Day, Year)	327	Registrar's Sign	ature	A							

State Registrar fresh

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #30, perDWR, C876, 2/1/08 TICertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** MARY EVA RUDMAN anuary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FAHRNEY-KEEDY HOME & VILLAGE WASHINGTON BOONSBORO If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth 5. Social Securify Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months (Month, Day, Year) 07/01/1916 Days Hours 061-01-7860 91 ROMANIA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10b. County 1 ☐ Yes 2 No Director MD FREDERICK MYERSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11643 MEETING HOUSE ROAD 21773 USA Items 23a r than "natural", or Items 23a the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No WHITE Specify Specify 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry filed within 72 (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 hand Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS CLOTHING permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other any Injury or other traumatic event; 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARRY GERTSON LERNER JENNY ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ,1 and 2 sh if Health ar item 27 ls FRED L. RUDMAN / SON 11643 MEETING HOUSE ROAD, MYERSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State SHAAREI TFILOH CONG. 01/31/2008 BALTIMORE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Total 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) In ronic Due to (or as a consequence of): /Medical Fin Examiner ADILL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes 27 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 within 24 hours efter death. To the Funeral Director: After this filled n by the functal 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ANatural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 152723

31. Date filed (Month, Day, Year) State Registrar 2008 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** LANUARY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1□M 2**X**F Year) Months Yrs. BALTIMORE **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director DALTI MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2105 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Haima $^{\prime}$ α 18. Mother's Name (First, Middle, Maiden Surnaine) 17. Father's Name (First, Middle, Last) 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Slen 12246 timore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses BALTIMORE, MOZIZ34 Evans Funeral Chapel+ (remation Services-Parkwille 10 LA 23a. Part1. Enter the dis e.se, or corplications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only ne cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Costridium 245 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performe Brecs To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32 Registrar's Signature

cause of death (Item 23a) (Type, Print) 560/

29c. License number

GOI LOCH

29d. Date signed (Month, Day, Year)

RAVEN BOULEVAR E, MARYLAM ZIZ

DHMH 17 Rev 1/2001

OCME 2006

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

Margarita Korell MD.

214 me

FFR

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

130K

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 26, 2008

within 24 hours a

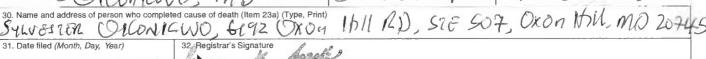
To the Funeral L Medical State Registrar DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

HCONKWO, M

29b. Signature and title of certifier





D0055314

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 8:45 a M 26, Lorraine May Shomper 2008 January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. Montgomery 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
March 26, 1924 Wisconsin 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 💢 F 83 396-20-0706 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 6323 Tone Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 f Yes, Give /ear or Dates: WWII 1 ☐ Yes 2 X No Specify. Specify: White ۵ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Librarian Federal Government 12 or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Louis Meyer Mathilda Brunner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dean Kenneth Shomper/Husband 6323 Tone Court, Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation January 27 3 Removal from State Bethesda, MD 4 ☐ Donation 5 ☐ Other (Specify) Cremătorium, Inc. 2008 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 755/ Wisconsin Avenue M01346 Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final Pulmonary Embolism **Physician** disease or condition resulting in death) 10 Days /Medical Due to (or as a consequence of): **Examiner** Metastatic Lung Cancer Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Pneumonia, malignant plural effusion 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No myocardial infarction, coagulopathy 24a. Was an page 2 s autopsy performed' hypertension 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Hospital or Attending 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 26, 2008 D17656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tipaporn Woodward M.D 5530 Wisconsin Avenue #550 Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year) 32. Segistrar's Signature

Division or Vital Records, P.O. Box 68760

State Registrar

DHMH 17 Rev 1/2001

2008

1	-	For State Registrar

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			Cei	rtificate	of L	Death			Reg. N	No.			
			1. Decedent's Name (First, Middle	, Last)								Date of Death Month Day Year Year				h
	Physicia Medic		Christopher E.		Jun				iem 27 2008 645PM							
	Examin		4a. Facility Name (If not institution		4b. City, Town, or Location of Death					4c. County of Death						
100	xaiiiii		Shady Grove Adv		Rockville					M	lontgom	ery				
_	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1		If Under	24 Hrs.	8. Date of B	irth /-	9. Birthplace (State or Foreign			əign
	Director		494-26-9446	1 ⊠ M 2□ F	80	Yrs.	Months	Days	Hours	Min.	Dec. 2	15, real	1927 Mi	Coun SSC	uri	
	Man and		Usual Residence of Decedent													
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It health and Mental Hygiene. Items 23s or 28se-f show Items 27s marked other than "natural", or Items 23s or 28se-f show other traumatic event, the Medical Examiner must be notified at		10a. State 10b. County		10c. City	y, Town or Lo	cation			_				1	d. Inside City Lin	nits
		to	Maryland Montgo	mery	01ne	·y									1	No
		Director	10e. Street and Number				10f. Zip (Code				10g. C	Ditizen of Wha	t Coun	try?	
			16710 Gooseneck	Terrace			208	32				Uni	ited St	ate	S	
		Funeral	11. Marital Status		cedent Ever in U.	S. 13. 1			ispanic Ori	idin? (Spe	cify Yes or N	0-	14. Race - A	Americ	an Indian.	
		F.	1 ☐ Never Married 2 ☐ Marri	Armed F			f Yes, speci	ify Cuba	n, Mexicai	n, Puèrto	cify Yes or N Rican, etc.)		Black, V	Vhite,	etc.	
21215-0036	Irs a	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive	т	1 ☐ Yes 2	☑ No	Specify:				Specify:	Whi	.te	
ŏ	thor sture	pe	15. Decedent	t's Education		10.0	dent's Usual	Occupa	ation			16b.	Kind of Busin	ess/Inc	lustry	
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≥	should and Men marke	ပ္	19a. Informant's Name/Relations			19h Mailir	na Address ((Street a				her Cit	y or Town, Sta	te Zin	Code)	
Maryland	d 2 s th ar 7 is trau		Marilyn Margare		Daughter		-							. ,	nd 20876	
ď	ss 1 and of Health Item 27 other tr		20a. Method of Disposition	.c orden /	20b. F	Place of Dispo	sition (Name	e of	i		Date		Location - City			
altimore,	Pages nent of int: If Its iry or o		1 X Burial 2 ☐ Cremation		n State	emetery, crei	natory or oti	her plac	· i							,
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Bai	permit. Pages Department of Important: If It any injury or o once.		21. Signature of Funeral Service	icense		Rô	bert A	Addre	umph	rey E	[uneral	Но	me/Roc	kvi	lle, Inc	· -
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L.			23a. Part1. Enter the disease, or shock, or hear failure. List	complications that only one cause on	caused the deatl	h. Do not ent	er the mode	of yin	g, such as	cardiac o	or respiratory	arrest,			Approximate Interval Between	
	Physician	1	Immediate Cause (Final disease or condition		nono	¿ enc	RIKK	los	WHI	40					Onset and Death	
	/Medical		resulting in death)	Due to	(or a conseq	uence of):	1	01	nn	1				1	- V-J-	
	Examiner		*	1 to 0	lentric	when	he	kri	eller	Th						
20		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseq	uence of):	-11	~								
9.	cutec id ansi	Examiner	Cause (Disease or injury that initiated events c.							l						
o n	execting and and rial-th	EX	resulting in death) Last Due to (or as a consequence of):													
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9	ificat g ph) as th	/Medical														
ŏ	0 2 2 1		IF FEMALE: 23b. Was decedent pregnant		utcome pf pregna								23d. Date of	f delive	ry	
ഥ	The law requires that the death cerate has been signed by the attendir page 2 should be detached for use	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2□Feta nant at time of d]Ectopic pre]Other <i>(sp</i> e		/				Month		Day Year	
P.O.	the cy y the	ıysi	9 Unknown	9□Unki	nown											
σ.	that ed b deta	<u>P</u>	Part II. Other significant condition	ns contributing to	death but not resi	ulting in the u	nderlying ca	use give	en in Part I	l.	23e. Did	tobacco	o use contribu	te to th	e cause of death	?
g	uires sign d be	d by	Cardwall	monay	anes	1					1 🗆	Yes	1 □No 3[] Prob	ably 4 ☐ Unkno	own
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Records,	e lav has le 2 s	Completed										opsy	prio	r to cor	osy findings availa npletion of cause	of
	sician: The law certificate has t irector, page 2 s	S									1□ Yes	formed?	No 1 🗍	Yes	2□ No	
Vita	Attending Physician: r death. ector: After this certifics by the funeral director, p	Be	25. Was case referred to medical examiner?					Oth		e of Death	(Check only	ond)_				
5	Physic this cral dire	2	1 ☐ Yes 2 → No	'-		ER/Outpatier			4 ∐ NL				6 ☐Other (Specif	/)	
	ding P h. After t		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Dlate (Mo	e of Injury nth, Day Year)	28b. Time of Injury	f 28	Bc. Injury Work	y at k?	2	28d. Describe	how in	jury occurred			
<u>0</u>	endi ath. or: A he fu	atic	& ☐ Accident investig	ation			М	10	Yes 2□	No						
Division or	er de rect	tific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined Zoe. Flac	e of injury - At ho ding, etc. (Specif	ome, farm, str	eet, factory,	office		2	28f. Location City or To	(Street	and Number o	r Rura	l Route Number,	
	tal o	Certification:														
	e Hospital or Attend 24 hours after death 2 Funeral Director: etely filled in by the f		29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To th Examiner: On the	ne best of my kno	wledge, deat	n occurred a	at the tin	ne, date ar	nd place,	and due to th	e cause	e(s) and manne	er as s	ated.	
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	one)	and ma	nner stated.	orr and/OF III					ou at the tills	, vait i	and place, allu	- uue (((30000)	
	To the within 2 To the complet	≥	29b. Signature and title of certifier	11/	1.		29c.	License	e number	3		29d. [Date signed (A	Nonth,	Day, Year)	V
			Mul	(Mo	noce	-		29	45	5		121	Mary	人	1 1000	2
	~ X\		30. Name and address of person	who completed car	use of death (Item	n 23a) (Type,	Print) /		00	0	11 12	6		h-r-		
	12,		ARAN (CHA)	VAVEI	15225	Shad	/ /.	W	Rd	Ku	Kvill	6	MD 2	00	7 Love	
	Sta	te	31. Date filed (Morith, Day, Year)	32	Registrar's Signa		/									
	Registr		250 0 1	2008		4	ill o									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Scott Physician 2:40 AM Morton anuary 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner VA Extended Care Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5, Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1**X**]M 2□F 212-26-8735 78 Director Mar 1, 1929 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show r 28a-f show notified at 1√2 Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? be l 524 N. Charles Street 21201 USA ns 23a must b Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Armed Forces: 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: \$51-54 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: black Completed by 3 ☐ Widowed 4 ₺ Divorced 7 Is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) self employed permit. Pages 1 and 2 should be filee.
Department of Health and Mental Hygin Important: if item 27 is marked any injury or other to once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Simon P. Scott Frances Estella Johnson ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8739 Meadow Heights Road Randallstown, MD 21133 Loretta Hopkins/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Sign ture of Lineral Service Licensee Ronal h S. Wade Director State Anatomy Board 655 W. Baltimore Street 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Prostate Metastatic Immediate use (Final disease or condition resulting in death) ancer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed Due to (or as a consequence of) Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 Live birth 3 Ectopic pregnancy for in the past 12 months? 4☐Pregnant at time of death signed by the at a be detached for 5 Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No The law I 24a. Was an has autopsy performed certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🖾 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of 28d. Describe how injury occurred

Division or Vital Records, P.O. Box 68760, After or Attending death.

Hospital

Baltimore, Maryland 21215-0036

Medical Certification: To within 24 hours after death

To the Funeral Director:
completely filled in by the

27. Man r of Death 28a. Date of Injury (Month, Day Year) Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Sulcide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier (Check only one)	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the									
29b. Signature and	title of certifier		Λ		MIN	29c. License number	29d. Date signed (Month, Day, Year			

rge E. Wills # MD. 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

133400

e E. Wills ## MD. D41365 January 26, 2008

rison who completed cause of death (Item 23a) (Type, Print)

Wicks ## M.D. 3900 Loch Raven Boulevard, Baltimore, Marylan

21218

State Registrar

31. Date filed (Month, Day, Year)

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** January 2008 EDRA JANENE TAFERT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Agnes Hospital Baltimore Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗙 F JUNE 18, 62 WV Director 212-46-6306 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 XYes 2 □ No Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 3173 KESSLER RD 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itel any injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8TH FACTORY FACTORY WORKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٥ JACOB NETZER EUDORA NETZER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH PHILLIPS 3173 KESSLER RD., BALTIMORE, MD21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5500 O DONNELL ST. 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/01/2008 | BALTIMORE, MD 21224 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Ser 2007-09 EASTERN AVE., BALTIMORE, MD complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death 2 days 23a. Part1. Enter the diseas shock, or heart failus. Chronic Obstructive Pulmonary Disease Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner and resulting in death) Last Due to (or as a consequence of): by the attending physician Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year 5 Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 □ No 3 Probably 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No after death.

Director: After this certificate I 1□ Yes 25. Was case referred to medical examine 1 lower 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1 $\mathcal{L} + \mathcal{E} \mathcal{L} + \mathcal{L} \mathcal{L} \mathcal{L}$ Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: To the Hospital within 24 hours a To the Funeral C completely filled

> 1 State

Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alice Tang 900 Catton Ave. BaH Alice Tang 31. Date filed (Month, Day, Year)

29b. Signature and title of certific

29a. Certifier

Caton Ave. Baltimore, MD 21229

32/Registrar's Signature Se September

D.O.

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

H62867

29d. Date signed (Month, Day, Year)

January 27 2008

MARGARET Vital TRUNK, Division

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2008

JANUARY

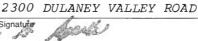
 O_{i}

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAREY, RICHARD, M.D. State

29b. Signature and title of certifier

UU-

32 Registrar's Signature



29c. License number

D31926

29d. Date signed (Month, Day, Year) 1/22/09

21093

MD

TIMONIUM

Registrar

(2)

State Registrar DR ROBERT

FRANKIN

32. Registrar's Stonature

MO

A. Paz

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000

062373

Souge DR BALMORE, MD

01-31-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Marguis IERNAN ames /Medical 30, 2008 4c. County of Death January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson If Under 1 Year | If Under 24 Hrs. Greater Baltimore Medical Center Baltimore 6. Sex 12 M 2 ☐ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 313-50-1945 Usual Residence of Decedent Director Baltimo re Mr 1944 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show be notified at 1 ☐ Yes 2 No BALTIMORE Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21234 "natural", or items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Black, White, etc. 1 ☐ Never Married 2 🕱 Married 1 ☐ Yes 2 🗖 No Specify Specify: 3 Widowed 4 Divorced White Baltimore, Maryland 21215-00 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Musicia permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important; If item 27 is marked other tha any Injury or other traumatic event, the once. 1 d 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RNAN tanton ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore Rd. Forest Valley MD 21234 liernan-wit m t20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory, or other place) 20c. Location - City or Town, State 108 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatule of Funeral Service dicens 22. Name and Address of Facility PORDED BALTIMOREND 21234 Evans Funeral Chapel + Genation 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each the. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cardismyopath **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ tachucard 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an page 2 certificate 1□ Yes 2 1 No To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0051347 Small, MD 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St Baltimore MD 21204 4nthia Joriano 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

0845

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** CI38 PM 24 JAN 2008 Phillip Wayne Tucker, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMOR SAINT AGNES HOSPITAL If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs, last birthday) **Funeral** Days **№** М 2 🗆 F Yrs. 218-44-5256 1944 Maryland Director 63 28, Auq. Usual Residence of Decedent r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Marvland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 21228 USA Dunvegan Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian natural", or items 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify: þ White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wi f Health and Mental Hygier item 27 is marked other th 12 <u>Computer Specialist</u> Admin 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Earl Lydia Johnson Tucker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Trotter Rd., Clarksville, Maryland 21029 Cherie Congedo- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Jan. 30,2008 Alexandria, Virginia Metropolitan Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home, INC. M0/234 7601 Sandy Spring Road, Aaurel MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. arrest. Immediate Cause (Final **Physician** disease or condition resulting in death) HEAD ON KHONIN PPROVED BY MEDICAL EXAMINES /Medical Due to (or as a consequence of) Examiner SUB DUR UNKNOWN Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-trans CERTIFICATION Due to (or as a consequence of) physician Physician/Medical the as attending properties as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical examiner?

1 ✓ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 □ ER/Outpatient 3 □ DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 X No 2 Accident UNK tal Director: d in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building,-etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 Dunvegan Kond Residence

be executed Box 68760, P.0. Records, or Vital

Maryland 21215-0036

Baltimore,

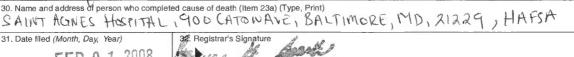
the Hospital or Attending hin 24 hours after death. To the Hospius.
within 24 hours after
To the Funeral Dir

5

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

29a. Certifier



2008

and manner stated

29c. License number

Catansville, Mb

29d. Date signed (Month, Day, Year)

JANUARY 28TH 2008

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008

2. Date of Death

Month

02673

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

5 months

Day

Year

Month

29d. Date signed (Month, Day, Year)

January 25, 2008

1KIYes 2 No

New York

Black, White, etc.

11:20 A.M

and manner stated.

32. Regiar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

State Registrar DHMH 17 Rev 1/2001

OXI

29b. Signature and title of ceptifier

31. Date filed (Month, Day, Year)

Bruce Kressel, M.D.,

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

29c. License number

5530 Wisconsin Ave., #1125, Chevy Chase, MD 20815

D0023600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 745 Month Year **Physician** THOMAS 2008 Tannaly 31 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balti more Hospital Randallstown NorthWEST If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 😿 F 212-24-8644 81 Director 03-16-1926 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits flied within 72 hours after death with the Marylan Hyglene. Volter than "natural", or items 23a or 28a-f show other than Medical Examiner must be notified at MD BALTIMORE Yes 2□No RANDALLSTOWN Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5107 OLD COURT ROAD

Marital Status

12. Was Decedent Ever in U.S. Armed Forces?

Armed Forces? Funeral USA 21133

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 **BOOKKEEPING** BUSINESS permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other i any injury or other traumatic event, <u>th</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES P. KNOX SYLVIA THOMAS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILTON J. THOMAS/HUSBAND 5107 OLD COURT RD., RANDALLSTOWN, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State MD. NATIONAL MEM. PK 02/07/2008 LAUREL, MD 4 □ Donation 5 □ Other (Specify) 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Waknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 100 1∐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Plospital or Attending Plant Plant Structure of Plant Structure of Puneral Director; After the structure of 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only To the I within 2, To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

, 5401 Old Court Road, Randallstown, MD Kafrouri 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D65843

January, 31, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** MILDRED ANN THOMPSON /Medical JANUARY 27, 2008 2:30 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Tender Loving Care Edgewood Harford If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 M 2 F Director 213-30-0399 76 22, 1931 Maryland Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland | Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 2519 Linwood Road Funeral ral", or items ? Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: ģ 3 Widowed 4 Divorced White Completed er than "natur the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) th and Mental Hygier
7 is marked other the Bank Teller Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be ဥ Marie Kopczeski Edward (unk) Brofka **T**eresa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 2 Donna Bannon / Daughter 1701 Stephens Place, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State = 0 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Hilltop Service Corp 2-1-08 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ASPIRATION PNEUMONTA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ATHTROSCUEROTIC CARDIOVASCUEARDISENS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HETHERIS law requires that the death certificate be executed DEMENTIA physician and s the burial-tran Due to (or as a consequence of) O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred i or Attending Fafter death. Division 1 Naturai Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Hospital 29a. Certifier 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

Medical

(Check only

29b. Signature and title of contifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D&& 16389

WHLARAO M.D. 1716 HARFORD Rd Suite 105 FALLSTONMS

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician Month 6:18 A VANIJAKY Gwendolyn Tucker Valerie 30 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMOLE GETISIS HAMILTON CONTON If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9/12/56 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 51 Texas **Director** 224-84-5928 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or : edical Examiner πust be n 21205 U.S.A 931 N. Luzerne Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade J.H.H Year Support Tech permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allen Walter L. Tucker Gertrune 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1527 Piper Square #B Hopewell, VA 23860 Gertrune Tucker-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem Park 2/4/08 Randallstown, MD 21. Signature of Foral Service Licensee 22. Name and Address of Facility March F/H 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility March F/H East E.North Ave Baltimore, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HEAKT CONGESTIVE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any sea in the immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 ☐N6 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OBSTRUCTIVE SLOW APNOCA. 1 Yes 2 → Yo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No L+MPHADENOPATITY 24a. Was an autonsy performed? 1 Yes 2 No ABDOMEN) 25. Was case referred to medical examino? 1 ☐ res 2 ☐ No 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Narsing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide

certificate be executed Box 68760, the as for Records, P.O.

Division or Vital

Maryland 21215-0036

Baltimore,

than

attending physician certificate

this

Director: After Hospital or Attending 124 hours after death.

To the Hospital within 24 hours at To the Funeral E

filled in by

Medical

4 Homicide

29b. Signature and title of certifier

29a. Certifier

6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Decritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

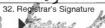
> 29c. License number 200 63339

JONI ANY 30 200 8

29d. Date signed (Month, Day, Year)

Print) DR MMU NAING OO, MD SUITE 4200, TOWSON, MD 21204 30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print) CHARLES St NORTH

State Registrar 31. Date filed (Month, Day, Year) FEB 0



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Vanden, III 7:50 PM Greenge 200 3 30 /Medical 00 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Barlowa Balhonere Yackulu TEMESIS 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 1**X** M 2□F 50-1019 Yrs. 3/41 Director itornia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo TIMORE 10g. Citizen of What Country? 10e. Street and Number 234 21 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tronic rederal ngineer Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vanden 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bras well MD Parkville 20a. Method of Disposition
1 ☐ Burial 2 【Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 108. 4 ☐ Donation 5 ☐ Other (Specify) Evanstringial Chapel Bel Air Forest 21. Signature of Funeral Service Licensee Rd., Baltimore, MD 21234. "Cremation Services-Parkville se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician Fred ericklo igears /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has autopsy performed 2 2 100 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Division or Vital Records, P.O. Box 68760 dea h. within 24 hours after dea To the Funeral Director

Hospital

Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

Registrar

31. Date filed (Month, Day, Year) State 0 FEB

29b. Signature and title of certifier

KlOUSZ

Suita 4262 N Charles St 6701 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 110 P Elizabeth O'Steen Valliere January 23, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Year) 1 □ M 2 🗓 F Director 577-44-1167 76 December 1931 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes XX No Director Maryland Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6415 Sandy Street 20707 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2ÅNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 'natural', or 1 □ Yes ŽŽ No Specify: White þ 3XX Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) US Govt. Secretary is 1 and 2 should be filed vif Health and Mental Hygie item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Furr Anna May Luskey ပ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pamela O'Steen-daughter 6415 Sandy St., Laurel, Maryland 20707 permit. Pages 1 ar Department of Hea 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important; If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Jan.29,2008 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Fleck Funeral Home. INC. W Mo1234 7601 Sandy Spring Rd., Laurel, MD 20707 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Recurrent Pleural Effusion disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Multiple Myeloma Sequentially list conditions, if any leading to in regular cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for each consequence of: Examiner Lymphoma physician and s the burial-trans Due to (or as a consequence of): Physician/Medical Sepsis as the attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy 5 in the past 12 months? Day Month Year 5 ☐ Other (specify) 4□Pregnant at time of death ☐Yes 2☐No the 9□Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy perform certificate 1□ Yes 2□No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 P 1 Yes 1 Hnpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral of 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 4 atural death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determin 4 Homicide

Division or Vital Records, Hospital or Attending Physician: the Funeral Director: npletely filled in by the hours

24

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P.O. Box 68760,

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Registrar

Medical

Maria D'Arbella, 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

29a, Certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008



1 🖰 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D62520

29c. License number

29d. Date signed (Month, Day, Year)

January 24, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend 19a, perFH 0876, 2/1/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** KOBERT WILLIAMS 0525 JANUARY 27 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 € M 2 □ F 02-23-1960 Maryland Director 220-72-4070 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show r 28a-f show notified at 1 ☐ Yes 2X No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 21015 U.S.A. Funeral 1949 Cypress Drive within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Specify: ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. other than ' Elementary/Secondary (0-12) College (1-4or 5+) t and 2 should be filed w Health and Mental Hygier om 27 Is marked other tt Manufacturing Company <u>Manager</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shirley Glean CLifton Williams 19a. Informant's Name/Relationship (Type. Print)
Rhonda K. Williams (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar.
Important; If item 27 Is
any injury or other trau
once. 1949 Cypress Drive Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gar. | 01-30-2008 Bel Air, Maryland 4 □ Donation 5 □ Other (Specify) 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** EPITHELIOID HEMANGIOENDOTHELIOMA 6 MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Clus to for as a consecuence of Examine burial-transit and Due to (or as a consequence of): Box 68760 physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate i 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 🔲 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death. 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1/21 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

VERDYIQUE

31. Date filed (Month, Pay,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NUSSENBLAT MD

32. Régistrar's Signaturé

Mark S

RES- 000

600 N. WOLFE STREET, BALTIMORE, MARYLAND 21287

JANUARY, 27,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 02680 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 01-27-08 10:10 pM Frances Weber /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Severna Park Severna Park Center Anne Arundel 8. Date of Birth (Month, Day, Year) 02-22-1915 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2 😡 F 92 Yrs MD 213-38-6494 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "neture!", or iteme 23s or 28s-f show the Modical Examinar must be notified at 1 ☐ Yes 2X No Directo Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21144 7802 Cypress Landing Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Be Completed by 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) Coffege (1-4or 5+) Hospital 9 X-Ray Technician permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othe any injury or other traumatic event 20c8. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara Matejka Ludwig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7802 Cypress Landing Rd. Severn MD 21144 Anne Yakaitis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/31/08_ Baltimore MD Bohemian National 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 9705 Belair Rd. Nottingham MD 21236 16 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) dementice **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🕽 ¥6 ed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown signed a Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ukknown should 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 🗌 Yes 2 10 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 Yes 2 N 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 Tyes 2 No investigation death. Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier of death (ftem 23a) (Type, Print) rens thou Millersville MD 21108 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 Jan. **Physician** 28, Robert Benjamin Willis , Jr. 17:53 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil E1kton Union Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In vrs. last birthday) **Funeral** 12 M 2□ F Months Days Hours Min. 06.14.1926 VΆ Director 231.20.2217 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 ☐No Director Cecil MD Conowingo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be U.S.A. 21918 4 Woodside Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: W 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: \$ White 3™Widowed 4 □ Divorced WWI 'natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) Agriculture 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Esther Cardwell Hicks Robert Benjamin Willis, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a 4 Woodside, Conowingo, MD Joan Henly/Daughter other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Injury or permit. Page Department of Important; If any Injury or once. 02.05.08 Garrison Forest Cem. Owings Mills, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 8717 Green Pastures 21. Signature of Funeral Service Licensee M0144 Stephen Lohmann PA TOWSONMD Approximate Interval Between Onset and Death 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician septic shock selondery disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of): Examine physician and s the burial-trans Due to (or as a consequence of) Physician/Medical as signed by the attending I be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 7 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe HyperKalemia 1 Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760, P.O. I Records, Division or Vital To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral.

has

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filed within 72 hours after Hygiene.

Maryland 21215-0036

DHMH 17 Rev 1/2001

State Registrar

(ed 31. Date filed (Month, Day, Year)

> EB 0

29b. Signature and title of certifier

29a. Certifier (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V4100 32 Registrar's Signature

106 Bow Street Elleton, MD Hospital

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00055190

29d. Date signed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UUS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 33 TOSEPHINE 10:25 PM 09 200 B 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death MANORCARE NURSING CENTER BALTIMORE N/AIf Under 1 Year | If Under 24 Hrs. 6 Sex Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Days 1 ☐ M 2 🕅 F 219-32-1636 MARYLAND 71 9-3-1936 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. BALTIMORE RANDALLSTOWN 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3837 JANBROOK RD. 21133 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Tes 2000 Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12--4-TEACHER BALTIMORE CITY SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ALEXANDER R. BOOKER SALLIE McGHEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEON WILLIS (HUSBAND) 3837 JANBROOK RD. RANDALLSTOWN, MARYLAND 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2/☐ Cremation 3 Removal from State GARRISON FOREST VETERANS 2-4-2008 OWINGS MILLS, MARYLAND * 4 ☐ Donation 5 Other (Specify) 21. Signature of Fineral Service Licensee ONATHAN D. HIBNER. Name and Address of Facility REDD FUNERAL SERVICE ,1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each line.

Imm of a Cause (Final disease or condition resulting in death)

a. SEPTICEMIA Approximate Interval Between Onset and Death Due to (or as a consequence of): OSTRIDIUM COLITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES MELLITUS 4 @Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗋 Homicide Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records. death.

Physician

/Medical

Examiner

Funeral

Director

ral', or itams 23a or 28a-f show Examiner must be notified at

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Physician /Medical

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Baltimore, Maryland 21215-0036

the attending physicien for use detached page 2 should be has certificate this After s after death filled in by within 24 hours a To the Funerel L the

> State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of certifier

BUSINESS 32 egistrar's Signature

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CENTER DRIVE Grand 1

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

D005910+

29d. Date signed (Month, Day, Year)

REISTERSTOWN

2008

MD

ORIGINAL

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/Med	ical	Hilda Zdanis 4a. Facility Name (If not institution, giv	re street and number)		4b. City, Town,	or Location	Janua of Death	ary .	29,20 4c. Cour	nty of Deat	11:20 A	7
Exami	iner	314 Heron St. Na			Aberde				Har	ford		
Funera		5. Social Security Number 6.5	Sex 7. Age (In yrs	. last birthday)	If Under 1 Year Months Days		24 Hrs. 8. Date (Mont	of Birth h, Day, Y	'ear)	9. Birt	hplace (State or F	oreign
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aryla 2 should I and Meni 4 marke	^L	19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Stree	t and Numb	er or Rural Route N	lumber, (City or Tox	vn, State, 2	Zip Code)	
		John E. Zdanis		100	Box Thor	cn Rd.	Abingdo	n, M	D 210	09		
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6		30. Name and address of person who	ON UNELAO	em 23a) (Type	Print) 6716 H	ALPR	ORD Rd	Sui	fe 10	STA	USTERM	one
S Regis	tate trar	31. Date filed (Month-Day, Year)	008 33 Registrar's Sign	nature								

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

2008

		For State	State of Ma		partment of ertificate of	Health and M		2001	2 02685
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Funera		i i	Sex 7. Ag	e (In yrs. last birthda	y) If Under 1 Year Months Days		8. Date of Birth (Month, Day, May 15,	Year) 9. Bi	rthplace (State or Foreign ountry)
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rland ow		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
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23a c	Funeral Director	341 Colonial Dr:	ive		219	14	1	United Sta	ites
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To the Hawithin 24 To the Force complete	Medical	one)	aminer: On the basis of and manner sta	ited.			ed at the time, da	te and place, and du	e to the cause(s)
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State Registrar

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E .			titution, give street and number)	4b. City, To New V	wn, or Location of I	Death	Carroll	
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Funeral Director		5. Social Security Number 213-20-7275	6. Sex 7. A	85	Yrs. Months		Min. Aug 21		puntry) MD
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by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. Hearth and Mental Hygiene. It marked other than "matural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	일	19a. Informant's Name/Re	elationship (Type, Print)		19b. Mailing Address	(Street and Num	ber or Rural Route Numb Load Westmin	er, city or rown, sta nster. MD	21157
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more Pages 1: nent of H ant: If it		4 Donation 5 C	Other Specify:	Dru	id Ridge (
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumat	1	21. Signature of Funera	rvice Licensee		Pritt	Funeral	Home and C	napel, P.	A. 21157
	_	23a Part I Enter the dise	ease, or complications that caus	sed the death. Do	o not enter the mode	of dying, such as o	cardiac or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
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Div urs aft	lled	E 4	determined (Specify)	Local Stree					
Hosp 24 ho Fune	etely f		ertifying Physician: To the bes	t of my knowledg	ge, death occurred at ad/or investigation, in	the time, date and my opinion, death	occurred at the time, date	and place, and due	e to the cause(s)
To the within To the	duo	<u> </u>	and manner s	tated.		29c. License numb		29d. Date signed	(Month, Day, Year)
		29b. Signature and title	e or ceruiler			O.C.M.E.		January 12,	2008
Mar		Maryon	to Meynul	ee of death (Item	23a)				
10	ĺ	30. Name and address Margarita Kor	s of person who completed causell MD. Assistant Me	dical Examin	er 111 Penn	Street, Baltime	ore, MD 21201		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIPM/23a pt L per Phys. 1876 2/1/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 2008 26, 10:13 A ^M Calliope Tsoulias Braun January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

The base Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🗓 F Director 578-38-9884 76 11/16/1931 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Anne Arundel 1 ☐ Yes 2 No Edgewater Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1644 Fairhill Drive 21037 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 🚺 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th <u>Homemaker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dimitrios John Tsoulias 2 Chrisanthe Apostolakos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernhardt Braun/ Husband 1644 Fairhill Dr., Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 21. Signature of Funda Soprice Licensee 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory 1/28/08 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part I. Enter the Tsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Betweer Onset and Death Inours **Physician** disease or condition resulting in death) /Medical Examiner Cancer of Ampulla of Vater 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation death. 1 Yes 2 No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi who completed cause of death (Item 23a) (Type, Print) 10 3/69 J # 201: Stephen Killian 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Floyd Dwight Burch 18, 20:35 PM January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Months Days Hours Min.

April 25, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 5. 1927 1 XM 2 ☐ F Maryland Director 80 220-22-0249 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or iteme 23a or 28a-f ehow permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Heelih and Mental Hyglene.
Department: If Item 27 le marked other than "natural", or Iteme 23a or 28a-1 ehon eny Injury or other treumatic event, the Medical Examinat must be notified at once. 1 ☐ Yes 2 No Directo Churchville Maryland Harford 10e. Sireet and Number 10f. Zip Code 10g. Citizen of Whal Country? 3502 Aldino Road 21028-1925 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 1944-11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married White 1 Yes 2 No þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Armored Guard Supervisor 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Kaywood Harry J. Burch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3502 Aldino Rd. Churchville, Maryland 21028-1925 Lillian D. Burch (Vife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1/22/2008 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Zellman Funeral Home. P.A. 123 S. Washington St. Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications, or heart failure. List only one Do not enjer the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner RATIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physicien and s the burial-transit Physician: The law requires thet the death certificate be executed P.O. Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to geath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy lindings available prior to completion of cause of death? autopsy performed? Yes 20 No certificete 1□ Yes 2X No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Inpatient 1 Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 2 ER/Outpatient 3 DOA After this 27. Manner of Death Natural 2 Accident 28a. Dale of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred or Attending s after decret Air 5 Pending 1 Tes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

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completely filled certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) HARFORD MEMORIAL HI WYRE DE GRAC 100 36940 IVA M.D. UNION
32. Registrar's Signature UNION AVENUE, HAVRE DE 31. Date filed (Month, Day, Year) State Registrar 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deat 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** CLARA M. BELL 2008 JAN /Medical 4a. Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER If Under 1 Year 8. Date of Birth (Month, Day, Year) If Under 24 Hrs Social Security Number 6. Sex Birthplace (State or Foreign Country) Days 1 ☐ M 2 🖔 F 578-56-2025 SEP 24, VIRGINIA 1942 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director MARYLAND HARFORD HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 123 DEAVER STREET 21078 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. ≥ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSES ASSISTANT HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROY HARRISON, SR. ٩ ETHEL SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROBERT J. BELL, SR./ HUSBAND 123 DEAVER STREET, HAVRE DE GRACE, MARYLAND 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R.A. FERRIS & CO. INC. 4 Donation 5 DOther (Specify) 1/24/08 WEST CHESTER, PA 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, 21. Signature of Funeral Service Licensee Scott- Colonon 552 LEWIS STREET, HAVRE DE MARYLAND 21078 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that, aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of a chiline. Immediate Cause (Final disease or condition resulting in death) Year ue to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physiclan/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2XNo 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? c/clm.c autopsy 1□ Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 20 No Hospital: P 1 🖺 Yes 1 | Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

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Department of Health a Important: If Item 27 is any Injury or other trau

Physician

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Examiner

Pages 1 and 2 should

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death. To the Funeral Director: completely filled in by the hours 24

State Registrar

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29a. Certifier (Check only one)

31. Date filed (Month

29b. Signature and title of certific

29c. License number

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and planner stated.

29d. Date signed (Month, Day, Year)

e and a person who completed cause of death (Item 23a) (Type, Print)

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Year) Day

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** John William Barclay 20, 2008 4c. County of Death January /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner avre 7. Age (In yrs. last birthday) 69 Yrs. 8. Date of Birth July 25 Social Security Number **Funeral** 23, Year 938 Maryland 12 M 2□F 219-34-2693 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show sdical Examiner must be notified at 1 ☐ Yes 2 No Cecil Port Deposit Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21904 30 Stayman Drive USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify White 3 Widowed 4 Divorced Year or Dates Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of wark done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sand Blaster Ship Building Pages 1 and 2 should be filled wi ment of Heatth and Mental Hygier tant: If item 27 is marked other th Jury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John William Barclay, Sr. Dorothy McDougal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Stayman Drive Port Deposit, Maryland 21904 Gladys Barclay/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or New Bridge Cemetery 1-25-08 Colora, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Eacility
T. Foard Funeral Home, P.A.
1 S. Queen Street Rising Su 21. Signature of Funeral Service Lice Maryland 21911 Rising Sun, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate use (Final disease or andition resulting reath) **Physician** Venly urin U /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed Juman sician and burial-tran Due to (or as a consequence of): Physician/Medical the attending phase as the fyes, outcome pf pregnancy □Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) I□Yes 2□No signed by the a Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 2 No 3 Probably 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred examiner? director, to medical 26. Place of Death (Check only one) Other: 4 1 Hospital: 2****No Certification: To 1 □ Y**/e**s 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) 27. Man 28a. Date of Injury (Month, Day Year) her of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 6 ☐ Could not be 1 Natural 1 Yes 2 No 2 Accident 24 hours after deat e Funeral Director: 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 24 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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31. Date filed (Me

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32. Registrar's Signature

with the Maryland r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at death v filed within 72 hours after Hygiene. parmit. Pages 1 and 2 should be filed v Department of Haaith and Mental Hygie Important: If item 27 is marked other I any Injury or other traumatic event, <u>tit</u>

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

that the death certificata be execute attanding physician and for use as the burial-tran signad by t funeral director this

Division or Vital Records, P.O. Box 68760, aftar death. 24 hours a

Reg. No. 2008 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Ethel Baker 2008 3:15 AM 9 1 4c. County of Death Montgomery 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 12801 Columbia Pike #127 Silver Spring If Under 1 Year _ If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 X F 102 yrs. 578 22 9300 8/10/1905 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Montgomery 1X Yes 2 No Director Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 12801 Old Columbia Pike #127 20904 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Black þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cosmotologist Olive Beauty Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Calvin Dickerson Cora Howell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12801 Old Columbia Pike #127 Silver Spring,MD 20904 Delphea Dickerson niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/16/2008 Suitland, Maryland 4 □ Donation 5 □ Other (Specify) Lincoln Memorial 21. Signature of Funeral Service License 22. Name end Address of FacilityJohn T. Rhines Funeral Home LLC 3005 12th St. NE Washington, DC 20017 Miren 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure 1 Month Due to (or as a consequence of) b. Hypertension Years Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failure To Thrive 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/11/2008 DC-MD 12331 my my and address of person who completed cause of death (Ifem 23a) (Type, Print) 30. Name Jack Summers 2141 K Street NW Washington, DC 20037 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State JAN 17 ZUUO Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

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37	- 42		1. Decedent's Name (First, Middle, Last)				-		1	2. Date of Death		Year	3. Time of Death
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Months	1 Year Days	If Under 24 Hours	Min.	B. Date of Birth (Month, Day,	Year)	9. Birth Cou	place (State or Foreign intry)
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o uc	Jing After fune	ion:	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28	Bc. Injury Work	at ? ′es 2 ∐ No		3d. Describe ho	w injury occu	rred	
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	To the Hospital within 24 hours a To the Funerel I completely filled	edical C	29a. Certifying Phys (Check only one) 2 Medical Examin	icien: To the best of my kno er: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, death	place, ar occurre	nd due to the ca d at the time, da	ause(s) and mate and place	anner as , and due	stated. to the cause(s)
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		- 9	that the	uder	IM ,) 1	DH	647	13		Janu	WUD	18, 2008
1.1	, -		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,						1	1	18, 2008 20, MD 2174
<i>J</i>	1-2		Tind Hav	ndan,!	MD:	1130	00	54 C	_ (1. 1	1ager	votei	on, MD 2174
	Sta Regista	_	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	Carek	2			,	7		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 9876 2-26-08 vt State of Maryland Poepariment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician P^{M} Anna Marie Beck 15. 2008 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 3810 Chaneyville Road Calvert Owings If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 579-18-8858 6 Sex **Funeral** Months Days Hours 1 ☐ M 2 🗓 F Feb. 16, 1918 Washington, DC Director 89 Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours atter death with the Maryland 10c. City. Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo MD Calvert County Owings 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Owings U.S.A. 3810 Chaneyville Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Callege (1-4or 5+) Federal_Government 12 <u>Administrative Assistant</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be f Health and Mental item 27 is marked o Barbara McGowan John Joesph Donohue 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is in any injury or other traum once. 3810 Chaneyville Road, Owings, Maryland 20736 Barabara Stewart (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 22 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington, D.C. 2008 Mt. Olivet Cemetery 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-tran Due to (or as a consequence of): inding physician ause as the burial P.O. Box 68760, Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy atten for u Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I or Vital Records, Completed by 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No has certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 2 this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Division To the Hospital or Attending within 24 hours after death. Iniury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 9920 January 16, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20678 M.D. 110 Hospital Road, Suite 111, Prince Frederick, MD 32. Registrar's Signature J. Michael Brooks, 31. Date filed (Month, Day, Year) State JAN 1 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland			of Health <i>of Death</i>			ene 20	08	021	594
	×		Decedent's Name (First, Middle, Last)					2. Date of Death		Vone	3. Time of	Death
	Physici /Medic		Artie Elizabeth Cooper					Month January	28 2	Year 2008	1955	М
}	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, To	wn, or Location	of Death		4c. County	of Death		
			Harford Memorial Hospital		Havr	e de Gr	ace		Harf	ord		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I		If Under 1	Year If Unde Days Hours	er 24 Hrs.	8. Date of Birth	(ear)	9. Birthr	lace (State o	r Foreign
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	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	cation					1	0d. Inside Ci	tv Limits
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	the 1	rect	10e. Street and Number	ivie de	10f. Zip C			10	g. Citizen of \	What Cour	atry?	
	with with	0	4200 Webster-Lapidum Road			21078			U.S.		,	
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene 4 heby. When then "natural", or items 23s or 28s-f show dother then "natural", or items 23s or 28s-f show event, the Medical Examinar mast ke incitited at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.	S. 13. V	Was Deceder	nt of Hispanic O	rigin? (Spe	cify Yes or No-	14. Rac	e - Americ	an Indian,	
	riter	Ē	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 25 ☑ No	11	f Yes, specify	Cuban, Mexica	an, Puerto F	Rican, etc.)	Blad	ck, White,	etc.	
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	ding h. Afte fune	io I	1 Natural 5 Pending (Month, Day Year)	Injury	м	lnjury at Work? 1 ☐ Yes 2 ☐			anjuny cood.			
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	spits lours nersi fillec		29a. Certifying Physician: To the best of my know	wledge, death	occurred at	the time, date a	and place, a	and due to the cau	ise(s) and ma	anner as s	lated.	
	• Ho 24 h • Fu	Medical	(Check only 2 Medical Exeminer: On the basis of examinat one) and manner stated.	ion and/or inv	estigation, in	my opinion, de	ath occurre	ed at the time, dat	e and place,	and due to	the cause(s	;)
	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier		29c. L	icense number		29	d. Date signe	d (Month,	Day, Year)	
	-		m. Uf Cal, MD		DO	0610	2	0	1/30	0/0	8	
			30. Name and address of person who completed cause of death (Item	23a) (Type,	Print)	^	11	1	10	1 11		
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHERYL A. AYELSWORTH, M.D.

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Year)

SITY

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 15, 2008 **Physician** 8:51 AM ALDO CARLO CASTAGNETTI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Montgomery General Hospital Olney 8. Date of Birth (Month, Day, Ye Jan. 21, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1X M 2□ F Italy 72 1935 577-02-5853 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c, City, Town or Location 10b. County 1 ☐ Yes 2 No Be Completed by Funeral Director Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 United States 14116 North Gate Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White Specify. 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Car Dealership 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Ricciardi Carlo Castagnetti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Ann Castagnetti (Wife) 14116 North Gate Drive Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cem. Silver Spring, MD 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses 10 East Deer Park Dr. Gaithersburg, MD 20877 witer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** yeurs PATHEROSOJEro /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician the burial Physician/Medical attending properties for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown Completed 24a. Was an autopsy performed? 1☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
117 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PER/Outpatient 3 DOA 1 🗌 Inpatient Certification: To 27. Mann of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No M within 24 hours after death.

To the Funeral Director: A 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier

Division or Vital Records, P.O. Box 68760,

State Registrar

2

8

DHMH 17 Rev 1/2001

29b. Signature and title of certif

JOHN HERRING

31. Date filed (Month,

Day, Year)

2008

who completed cause of death (Item 23a) (Type, Print)

18/01

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0030414

PHILIPOR OLNEY, MARYLAND 20832

29d. Date signed (Month, Day, Year)

		1- State Of Ivial y is Registrar		rtificate of L		Re	g. No. 2008	3 02697
Physic	ian	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
/Medi	cal	Frances Edelen Cary		4h City Town or	Location of Death	January	16, 2008 4c. County of Dea	6:10a ^M
Exami	ner	4a. Facility Name (If not institution, give street and number) Arcola Health & Rehab. Center		Silver S				
Funeral			rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montg 9. Bir	thplace (State or Foreign
Director		579-30-4401 1 M 2 F 97 Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	(Month, Day, Feb. 17		shington, DC
Maryland f show ed at	or	,	City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2√√√No
the N 28a-	Directo	Maryland Montgomery 10e. Street and Number	S:	ilver Spr 10f. Zip Code	ing	10	g. Citizen of What Co	ountry?
3a or		llll University Blvd., W.	. Ant.		2090		USA	,
death	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?		Was Decedent of Hi If Yes, specify Cuba			14. Race - Ame	
be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 □ Never Married 2 □ Married 1 □ Yes Star No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:	Hican, etc.)	Black, White	
Mary Jiaina Z I Z I 3-0030 nd 2 should be filed within 72 hours af th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, th. Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of worki	ing 1	6b. Kind of Business.	/Industry
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ylannould be Mental arked o	To E	George Edelen			Alma	Hurtt		
Taryia 2 should and Men is marke aumatic	ľ	19a. informant's Name/Relationship (Type. Print)						Zip Code) MD 2090
and and m 27		William Randolph Cary/Son						ilver Spring,
partimore, Maryland permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic evenore.	/	1 ☑ Burial 2 □ Cremation 3 □ Removal from State	-	sition (Name of matory or other plac Lvet Ceme	^{e)} Janu	ary 22, 2	Oc. Location - City or Washingto	
Dall III permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	22	2. Name and Addres	ss of Facility			
		Dans & Daling	l i	Francis J 500 Unive	. Collins rsity Blv	Funeral d, W., S	Home Inc	ing, MD 2090]
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Examine		Sequentially list conditions, b.						
ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	sequence or):					
xecut and and	Examiner	that initiated events c	sequence of):					
ficate be executed a physician and is the burial-transit	<u>e</u>							
oof ou, tificate be executed ig physician and as the burial-transit	edical	0,						
		IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ F		∃Ectopic pregnancy			23d. Date of de	•
e dea the att	Physician/N	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown in the past 12 months? 4 □ Pregnant at time 9 □ Unknown		Other (specify)			Month	Day Year
The law requires that the death oe the has been signed by the attenditions age?		Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
HECOTOS, The law requires to the law been signed age 2 should be considered.	d by	Osteomyelitis, Cellulitis	,	, g cause gree				robably 4 2 Unknown
v requ	ompleted					24a. Was an		
sician: The law sertificate has birector, page 2 s	m du					autopsy perform	prior to	utopsy findings available completion of cause of
	e Co	25. Was case referred to medical			00 51			s 2□No
Physician: r this certifica	o Be	examiner?	ER/Outpatier	nt 3 DOA Othe	er: 4 De Nursing Ho		nce 6 □Other (Spe	no if all
Physer this eral d	-	27. Manner of Death 28a. Date of Injury	28b. Time of	f 28c, Injun	v at	28d. Describe hor		ecity)
I or Attending Phy after death. I Director: After this din by the funeral d	tion	1 Matural 5 ☐ Pending (Month, Day Yea 2 ☐ Accident investigation	r) Injury	M 1 □	Yes 2 □ No			
Atte	ifice	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - A building, etc. (Sp	t home, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or R	ural Route Number,
s affe	Certification:	Sullaing, etc. (op				Oity or Town,	Olaic)	
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examined and manner stated.	knowledge, deat nination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the ca red at the time, da	use(s) and manner a ate and place, and du	s stated. e to the cause(s)
To th withir To th	Me	29b. Signature and title of certifier		29c. License	e number	29	d. Date signed (Mon	th, Day, Year)
12		> Atmesia And	Lemo	D'	56691		1/17/2	800
12		30. Name and address of person who completed cause of death (Ghousia Sultana, MD 12107 H			ale Silv	er Shrin	g, MD 2090	
St	ato	- 49		Tark CIL	ore, prin	er shrru	g, MD 2090	
Regist			J. A	BALL				
DHMH 17 Boy 1/	0004		- 7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 24a, b per dr 6,02/16/08 hb Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ам 1/9/2008 7:00 Phyllis Ann Chandler /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Seasons Hospice Savage 8. Date of Birth (Month, Day, Year) 5/18/1930 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2X F 77 Virginia 223-30-4292 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10a. State show la or 28a-f show t be notified at 1X Yes 2 No Director Prince George's Berwyn Heights MD 10g. Citizen of What Country? 10e Street and Number 20740 U.S.A. 7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must be 8810 Edmonston Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 N Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify ģ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) University of Maryland College (1-4or 5+) Elementary/Secondary (0-12) College Park Executive Administrative Asst 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental Fayette Pulliam Lawrence Hagee 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27 John Chandler, Husband Edmonston Rd., Berwyn Heights, MD 20740 Important: If item 2 any injury or other Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 1/12/2008 Brentwood, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave Gasch's FUneral Home, P.A. Hyattsville, MD2078 23a. Part1. Enter the disease, or com lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): EPHROPATH **Examiner** 1worthhous tell vibritions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed physiclan and the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as IF FEMALE esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No certificate 2 XNo 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 100 Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ò the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State Registrar

8

29b. Signature and file of certifie

32. Registrar's Signature

29c. License number

Name and address of person who completed cause of death (Item 23a) (Type, Print)

A A A A A E LA I TOS DICITAL DRIVE LINTHICUN

DO06314

29d. Date signed (Month Dav. Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 02:05 M January 2008 George Robert Carr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital of Cecil County Elkton Ceci1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Director 161-14-3268 88 June 22,1919 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes ¾ No Director Maryland Cecil North East 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 47 Sunset Drive 21901 United States Funeral death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give 1941–45 Year or Dates: 1 ☐ Never Married 2 ▼ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Owner/President Milk Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Robert H. Carr Edith Duling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida Mae Carr / Wife 47 Sunset Drive, North East, Maryland 21901 January 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Paurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Sparts) 5 ☐ Other (Specify) / North East Methodist | 12, 2008 North East, Maryland 22. Name and Address of Facility Crouch Funeral Home 21. Signatur 127 South Main Street, North East, Maryland21901 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Fart1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Prevmothoro Tension /Médical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical as attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown cate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed?
1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 1 Yes To the Hospital or Attending Physician: rector, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ₩ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Injury 1 Natural 5 Pending s after dea... investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral D completely filled i Medical 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

24/14 State Registrar

Hospita 31. Date filed (Month, Day, Year) JAN 1 1 2008

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and a idress of berson who contribeted cause of death (Item 23a) (Type, Print) Dr Jeff Trongson Union Hospital, Eleton MD 31931

D0053309

29d. Date signed (Month, Day, Year)

January

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 12, Day 2008 Physician 8:10 p Jennie Carter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Doctor's Hospital Lanham PG If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/10/1918 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 😿 F 89 223-40-2658 Virgínia Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10a. State 10b. County 1 SyYes 2 No Director MD PG Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12849 Holiday Lane 20716 U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: Black þ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Self employed 4th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Lucy Carter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Johnson - Cousin 12849 Holiday Lane; Bowie, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/18/2008 Suitland, Maryland Lincoln Cemetery 21. Sign to re of Funeral Service 22. Name and Address of Facility Licenses Freeman Funeral Services 4594 Beech Road; Temple Hills, MD 20748 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1 Sinter the disease, of shock or heart failure. List Immediate Cause (Final Approximate Interval Between Onset and Death 72 days Respiratory Failure se or condition resulting in death) Due to (or as a consequence of) Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) □Yes 2□XNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ XUnknown Senility: Obstipation Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2√No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)

Physician /Medical Examiner

Funeral

Director

show

Items 23a or 28a-f

notified at

the Medical Examiner must be

"natural", or

and Mental Hygiene.

or other traumatic

permit. Pages 1 and 2 s Department of Health at Important: If item 27 Is any injury or other trau once.

Mental I

with the Maryland

death v

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed burial-tran the as use for detached page 2 certificate Hospital or Attending Physiclan: filled in by the funeral dir within 24 hours after deatt
To the Funeral Director:
completely filled in by the

P

Medical Certification:

29a. Certifier

(Check only one)

Division or Vital Records, P.O. Box 68760,

1 ☐ Yes 25 No 27. Manner of Death

5 ☐ Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

(Month, Day Year) Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2XXVo

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

of sertifie 29b. Signature and titl

29c. License number D-3U525

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

January 14, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. J. Rao, Md, 4000 Mitchellville Road, Suite 220; Bowie, MD 31. Date filed (Month, Day, Year) JAN 1 8 2008

28b. Time of

Registrar

32. Registrar's Signature

28a. Date of Injury

3

90

To the

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

within 2 2 State DHMH 17 Rev 1/2001

2008 Registrar

29b. Signature and title of certifier

29a. Certifier

Medical

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Virdell Cooper 7:00 P. M 15, 2008 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Hospital Center Cheverly Prince George's . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1**X** M 2□ F Director 251-58-1633 08/20/38 Folkston, Ga. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ns 23a or 28a-f show must be notified at Y⊟Yes 2 No Md. P.G. Hyattsville Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20784 6922 Decatur Place U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African-1 ☐ Yes 2 😿
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 No ò 1 ☐ Yes 2XXVo Baltimore, Maryland 21215-0036 Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced American "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than "natu Elementary/Secondary (0-12) College (1-4or 5+) Meat Selector Safeway Warehouse 11+h 7 Is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anderson Cooper Lillie Maude Williams ဥ 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vera M. Cooper/Wife 6922 Decatur Place, Hyattsville, Md. Health a item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cem. 01/22/08 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on people line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a pensequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician a s the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page perform 2 **N** No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Leat Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: / 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of bertifier and address of person who completed cause of death (Item 23a) (Type, Print) Cate venus 3001 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland		tificate of D		менан пу	Reg. No.	2008	02	703
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	E. Duti	1	SR.		2. Date of De Month Januar	Day	Year 2008	3. Time of 6:20	Death a ^M
	Examin		4a. Facility Name (If not institution, give s		'	4b. City, Town, or I		1	4c. 0	County of Death		
Swig .		s.	5. Social Security Number 6. Sex	Avenue 7. Age (In yrs. I	ast hirthday)		yville If Under 24 Hrs.	8. Date of Bir	th	Ced		- Foreign
	uneral irector			M 2□F 49	Yrs.	Months Days	Hours Min.	(Month, Da	ıy, Year)	58	place (State o intry) Mary	
yland	at		10a. State 10b. County	10c. City	, Town or Lo	cation	-				10d. Inside Cit	ty Limits
e Mar	a-f sh tified	ctor	Maryland Cecil			Perry	yville				1 X Yes	2 No
ith th	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	•	
ath w	s 23a nust t	ral	504 Susquehanna Av		a I		903			U.S.A		
Id yid II X I X I S-0030 2 should be filed within 72 hours after death with the Maryland and Mental Hvuiene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	 Was Decedent Ever in U.\$ Armed Forces? 1		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2XI No	spanic Origin? (Sind Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		4. Race - Ameri Black, White Specify:		
2 Por	ical E	ted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	dent's Usual Occupa	tion	kina	16b. Kin	d of Business/I	ndustry	
ithin 7	Med "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done do DO NOT use retired)		Killy		on Trucl ngdon, I	-	
iled w Hygiel	nt, the		Twelve Years 17. Father's Name (First, Middle, Last)	<u> </u>	<u> </u>	ruck Driv	er 18. Mother's Nan	ne (First, Middle	L		mar y ran	Id .
d be	ked o	To Be	Muncy Du	th				Jean M.				
shoul md M	mari	ř	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street a					ip Code)	
and 2 st	127 is er tra		Margaret A. Duty	(wife)	504 9	usquehann	a Avenue	e, Perry	ville	e, Mary	land 2	21903
es 1a of Hei	if item or oth		20a. Method of Disposition 1 ☐ Burial 2 【▼ Cremation 3 ☐ Re		lace of Dispo emetery, crer	sition (Name of matory or other place	e)	Date	20c. Loc	ation - City or T	Town, State	
Pages tment of	tant: jury o		4 Donation 5 Dother (Specify)	R.A		s & Co., Ind				hester, 1		ania
partification permit. Pages Department of	any In		21. Sign ture of Funeral Service License	all non	Le Le	R. Name and Address e A. Patt rryville,	s of Facility .erson & <u>Maryla</u> r	Son Fun	eral 3-076	Home, 1	P.A.	
/M Exa	edical iminer	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ		Structi	VeFu	l <i>man</i> a.	41	Sistase	Onset and t	<u> </u>
certificate be executed	ding physician and se as the burial-transit	ledical	IF FEMALE:	Due to (or as a consequence of pregnatic. If yes, outcome pf pregnatic.								
the death ce	been signed by the attending should be detached for use	Physician/IV	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			25	3d. Date of deli		Year
us, r	signed b	by	Part II. Other significant conditions con	inbuting to death but not resu	ulting in the u	nderlying cause give	n in Part I.		tobacco us Yes 2□	e contribute to		leath? Jnknown
The law requires that the death cer	ate has beel page 2 shou	Completed						24a. Was auto perfi 1∐ Yes	an psy ormed? 2 No	24b. Were aut prior to c death? 1 ☐ Yes	topsy findings ompletion of c	available ause of
VILCII	ertific ector,	Be	25. Was case referred to medical examiner?			1	26. Place of Dea	ath (Check only	•			
Physi	this c al dire	ပ္	1 ☐ Yes 2 ♣No	ospital: 1 Inpatient 2			4 Li Nursing F	lome 5 Res			eify)	
e ie -	After	ion:	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ? ∕es 2∐No	28d. Describe	now injury	occurred		
To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.8	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify					Street and wn, State)	Number or Ru	ral Route Num	ıber,
e Hospit 24 hours	e Funera letely fille	Medical (29a. Certifier 1 CertIfying Phys (Check only one)	iclan: To the best of my known er: On the basis of examination and manner stated.	wledge, deat tion and/or in	n occurred at the tim vestigation, in my op	e, date and place pinion, death occu	e, and due to the urred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s	3)
To th	To th	Me	29b. Signature and title of certifier			29c. License	number		29d. Date	signed (Month	, Day, Year)	
	-		Islaa M	. Clour MD		Dos	17471		Jaw	iony 16	200	8
5			30. Name and address of person who con	npleted cause of death (Item	23a) (Type,	Print) 01 111 W	est Hia	h Stree	+ 1	kton M	larylan	d 21921
Ě	Sta		31. Date filed (Month, Pay, Year) JAN 2 2 20	32. Registrar's Signa		harte		_				

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital within 24 hours a To the Funeral C

Be ဥ

Certification:

Medical

			24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of Death	n (Check only one)
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	OOA Other: 4 Nursing Ho	me 5 Residence 6 □Other (Specify)
27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time of Injury Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined		ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	hysiclan: To the best of my knowledge, death occurr miner: On the basis of examination and/or investigat and manner stated.		and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)

29c. License number

OCOMO CITY BUD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008

Black, White, etc.

White

10:20 A

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

1 ☐Yes 2 X No

BA12

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

JAN 1 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDWIN COTS 79200 A NO 10324 027 32 Registrar's Signature

			For State Registrar		State of IV	iai yiarii		ertificate of		-	Glerie Reg. No	17.13	08	0270
	7.7	- 1	Registrar Decedent's Nam	e (First, Middle, I	_ast)			or imouto or	Douin	2. Date of De				3. Time of Death
	Physicia /Medic		Debra	Parh	am Datche	er				Janua:	cy 1	y 6,20	Year 008	12:09A ^M
Y	Examin	. 1	4a. Facility Name (/	lf not institution, g	live street and number	•)		4b. City, Town, o	r Location of Death			County o	f Death	
		п	Souther	rn Mary	land Hos	pital	L	Cli	nton		P	rino	ce G	eorges
- C	Funeral		5. Social Security N		Sex 7. A	ge (In yrs. I		y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th			lace (State or Foreigr try)
- 11	Director		212-54-	-2666	1 □ M 2 🙀 F	57	7 Yrs.	World's Days	Hours Will.	July 1		950	Wa	sh.,DC
	D .		Usual Residence of			The St								
	rylar how lat	_	10a. State	10b. County		10c. City	, Town or l	Location					11	0d. Inside City Limits
	a-fs	당	Md.	PG			Clint	on						1 XYes 2 □ No
	th the	ire	10e. Street and Nu	mber				10f. Zip Code			10g. Cit	izen of W	hat Coun	try?
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	5320 We	est Bon	iwood Tu	rn		207	35		Uni	ted	Sta	tes
	dea ems er mu	ner	11. Marital Status		12. Was Deceden Armed Forces	t Ever in U.	S. 13	B. Was Decedent of H If Yes, specify Cub	lispanic Origin? (S	pecify Yes or No)-	14. Race	- America	
9	after or Ite mine		_	ried 2□ Married				1 □ Yes 212 No	Specify:	o 1 10 an 1 o 10 1)		Specify:	, ***********	Sto.
8	72 hours after natural", or Ite dical Examine	d by	3 Widowed	4 XDivorced	Year or Dates:							ореспу.	Bla	ck
5-	72 h "natu dical	etec	(Spec	15. Decedent's cify only highest of	Education grade completed)	- 1	16a. Dec	edent's Usual Occup le kind of work done . DO NOT use retire	pation during most of wor	king	16b. K	ind of Bus	siness/Ind	lustry
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.	Completed	Elementary/Seco	ondary (0-12)	College (1-4or	5+)		nistrati	•			Pri	vat	e
D	Hyg Hyg othe	BeC	17. Father's Name	(First, Middle, La	st)				18. Mother's Nan	ne (First, Middle	, Maiden	Surname	9)	
ılan	uld be denta rrked rific ev	To B	Charle	s Parh	am Sr.				Helen	Butle	r			
ar,	sho sand band sand sand sand sand sand sand sand s		19a. Informant's N	ame/Relationship	(Type. Print)			iling Address (Street			er, City o	or Town, S	State, Zip	Code)
	alth a		Andrea	Datche	r/daughte	er	437	O Big Hog glasvill position (Name of rematory or other pla	rn Pass	30135				
<u> </u>	s 1 s of He item othe		20a. Method of Dis		_	20b. P	lace of Dis	position (Name of	cel	Date	20c. Lo	ocation - 0	City or To	wn, State
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, ti ones.			☐Cremation 3 5 ☐ Other (Spe	☐Removal from State cify)	- I		ction Ce			Cl	into	on,	Md.
a E	permit. Departimport: any inj		21. Signature of Fu	uneral Service Lic	ensee f			22. Name and Addre						
Ω	8 3 5 6		Va	nna	Hodfe			3910 Sil	ver Hil	.1 Rd.,	Su	itla	ind,	Md.20746
V.			23a. Part1 Enter t	the disease, or co art failure. List or	mplications that of use ly one cause of each	ed the death line.	n. Do not e	nter the mode of dyi	ng, such as cardiad	or respiratory a	rrest,			Approximate Interval Between Onset and Death
	Physician	4	Immediate Cause disease or condition	(Final	a Sonti	cemio							Î	2 00
	/Medical		resulting in death)	4	Due to (or a			0						a de
	Evaminer	, ,			\ }	1							- 1	1 1 ()() () ~ ()

Division or Vital Records, P.O. Box 68760,

Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death da preumong Bilaker Due to (or as a consequence of): metastasis Diffuse Metal Due to for as a consequence of): unknown MENOW malignent 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 ☐ Unknowń Pai þ Completed 25 Be Certification: To 27

rt II. Other significant condition	s contributing to death but not res		se contribute to the cause of death? No 3 Probably 4 Mnknown			
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No	
. Was case referred to medical			nth (Check only one)			
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatient 3 □ D0	Home 5 ☐ Residence 6 ☐ Other (Specify)			
. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred	
3 ☐ Suicide 6 ☐ Could no determine		ome, farm, street, factor	28f. Location (Street and Number or Rural Route Number,			

3 □Ectopic pregnancy

5 ☐ Other (specify)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier Kermen 29c. License number 063183 29d. Date signed (Month, Day, Year)

20735

CLINTON -

Month

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KANNAN 7503 VALIV SARi SURRAM

Registrar

Medical

31. Date filed (Month, Day, Year) JAN 1 8 2008

32. Registrar's Signature

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification of the funeral director is the funeral director.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) Day Year **Physician** 11.28 AM 2008 01 Laura Dennis Beatrice /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner alsbury omice Under 1 Year / If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕱 F 81 Feb. 28. 1926 Maryland Director 213-24-1587 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Worcester Newark 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21841 USA 6755 Basket Switch Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Nidowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 7 ealth and Mental Hygiene. n 27 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) laborer Poultry Industry 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Helen Johnson Clarence Tingle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau <u> Alfreda Dennis-Bowyer/daughter</u> 129 Conley Drive, Chestertown, MD 21620 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Wesley UMC Cem. 01/26/2008 | Snow Hill, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD 21. Si mature of Funeral Service Licenses 21801 JOLLEY MEMORIAL CHAPEL, P.A. 23a. Part1. Enter the disease, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is listed as extended) Due to (or as a consequence of), Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □ Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Conknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy performed's La 2 **□** No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of after death.
I Director: After to din by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred ZNatural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State

Registrar

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, Year)

I Wieland

JAN 18 2008

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ennis

Beatrice

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

M. D. P. R. M.C. 100 E.

3 Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Carroll St. Salisbur

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 2:30 Charles Woodrow Fleming 2, 2008 Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex Social Security Number **Funeral** 1⊠M 2□F 7/31/1916 South Carolina Director 579-60-7216 91 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director Washington DC N/A10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20010 726 Quebec St. N.W. U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ 3 Widowed 4 Divorced American Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 5+ Assistant Principal D.C. Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William F. Fleming Lula Lillie Lee McKelley ပ 19a. Informant's Name/Relationship (Type. Print) Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 327 Longfellow St., N.W. e of Disposition (Name of Date D.C. 20011 Lula Mundy Sanderlin Wash. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State inlury 4 ☐ Donation 5 ☐ Other (Specify) 1/18/08 Suitland, MD Lincoln Mem. Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc

A^M

29d. Date signed (Month, Day, Year)

AJE. TAKOMA PACK, MD. 20912

Physician /Medical **Examiner**

signed by the a d be detached f 2 To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifical ours after death.
neral Director: A

one)

29b. Signature and title of certifier

30. Name and adding the state of the state o

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	I andré &	hompson	7400 Ged	orgia Ave	e., N.W. V	Vash. D	C. 20012
	shock, or heart failure. List only	plications that caused the death. Do none cause on each line.	3.1	1	or respiratory arrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or a consequence of	e Hea	rt tai	iure		
5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Hyperter	1510n	- ,			
	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Coronary Due to (or as a consequence of	Arter	y Disa	ease		
	(d					
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐Ectopic pregna 5 ☐ Other (specify			23d. Date of de Month	elivery Day Year
	Part II. Other significant conditions of	contributing to death but not resulting in	the underlying cause	given in Part I.		use contribute t	o the cause of death? Probably 4 Unknown
					24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of s
,	25. Was case referred to medical			26. Place of Dea	ath (Check only one)		
	examiner? 1 □ Yes 2 ▼ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	tpatient 3 DOA	Other: 4 Nursing F	lome 5 Residence	6 □Other (Spe	ecify)
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) II		njury at Work? I □ Yes 2 □ No	28d. Describe how inj	ury occurred	
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, far building, etc. (Specify)	rm, street, factory, offi	се	28f. Location (Street a City or Town, Sta		Rural Route Number,
3		nysician: To the best of my knowledge					

Registrar

State

and manner stated

DhitE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1/17/08 ertificate of Death State Registrar Amended # 20b Per FH, Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 3:20 PM 4a. Facility Name (If not institution, give street and number) 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Center
7. Age (In yrs. last birthday) HyaHsvi If Under 1 Year | If Und Prince 9. Birthplace (State of Foreign Country) Prince Georges
5. Social Security Number Sex 8. Date of Birth (Month, Day, Funeral Months Days 1 M 2 □ F Hours Min 24696300 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 1 Yes 2 No Director deorge. 10g. Citizen of What Country? 10e, Street and Numbe by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M/No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tical Cartographic Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brown Felton mnie 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NC 27909 Rev. John W. Felton/Brother 1339 Paxton Street, Elizabeth City 20b. Place of Disposition (Name of cemetery, crematory or other place) 2 Pate 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 2008 Elizabeth City- NC 4 ☐ Donation 5 ☐ Other (Specify) DOWN Grove 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Greene Funeral Home 314 Franklin Street Alexandria, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of): Examiner ALPS Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably ↓Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has b, page 2 s autopsy certificate 1□ Yes 🔀 No To the Hospital or Attending Physiclan: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) pital: Inpatient 28a. Date of Injury 1 ☐ Yes 2√ No 2 ER/Outpatient 3□ DOA After this of funeral dire မ 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 5 Pending Investigation (Month, Day Year) Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No Funeral Director: tely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Neclies Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time date and place, and due to the 29a. Certifier Medical To the Ful (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and ti 29c. License number 29d. Date signed (Month, Day, Year) 08 30. Name and addre ause of death (Item 23a) (Type, Print) erriMatin HOS 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 7 2008 Registrar

DHMH 17 Rev 1/2001

08-00	0467	
Brad	Alan	Fowler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

rad Alair i owie		1- For State Certificate of Death	, ,	Reg. No. 200	8 0270										
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of De	eath Year	3. Time of Death										
ledical Exami	ner	Blad Midi Towici	January	16, 2008	2115 hrs										
		4a. Facility Name (if not institution, give street and number) Rt. 231 at Yardley Drive 4b. City, Town, or Location of De Prince Frederick	eath	4c. County of Death Calvert											
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		irthplace (State or											
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any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits										
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Maryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	•										
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		865 Camp Conoy Road 20657 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	/ Specify Ves or N	United St	ates orican Indian, Black,										
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ours a atura xamir	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		16b. Kind of Business	Business/Industry										
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21215-0036 buld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Son	17. Father's Name (First, Middle, Last) 18. Mother's N	lame (First, Middle	, Maiden Surname)											
215 be file ntal H rked ent, t	Be		nda Joyce	Spaid											
O 21 thould nd Me is ma	မ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number		•											
MD and 2 sho salth and 2 ris		Brenda Fowler (Mother) 865 Camp Conoy Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	l, Lusby,	Maryland 2											
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		1 Burial 2 X Cremation 3 Removal from State crematory or other place)													
ti Pag t. Pag tment rtant:		4 Donation 5 Other Specify: Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility			la, Virginia										
Ba perm Depa Impo injur			Funeral Hom Marvland 206	•											
Physician		P. O. Box 600, Lusby, Maryland 20657 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval													
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Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2108 hrs 1 Yes 2 ✔ No	Driver aut	e how injury occurred of fixed object collis	ion and ejected										
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To t withi To tl	Medical	and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)													
	-	6.C.M.E.		January 17, 20											
		30. Name and address of person who completed cause of death (Item 23a)													
10		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	<u> </u>												
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Getzandanner Bessie Irene 2008 January 3:10P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glade Valley Nursing & Rehab. Ctr. Walkersville Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 15,1917 Hours Months Days 1 □ M 2 K F Yrs. 90 217-10-0344 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 □Yes 2XTNo Directo Maryland Frederick Thurmont 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8216 Rocky Ridge Rd. 21788 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced White Completed 7 is marked other than "natural traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laboratory technician research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Tyson Tregoning ပ္ Nora Mercer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr N. Wayne Getzandanner/stepson 8214 Rocky Ridge Rd. Thurmont, MD 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) McKaig Cemetery 1/31/2008 | nr. Mt. Pleasant, MD 21. Signification of Funeral Service Lice 22. Name and Address of Facility Hartzler Funeral Home O. 11802 Liberty Rd. Libertytown, MD 21762 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on such line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any learning to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the bunal-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 Other (specify) been signed by the should be detached 9. Unknown 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy certificate 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4. Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural Injury 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 687605 nours after death.

neral Director: Af

filled in by the fur To the Hospital o within 24 hours aft To the Funeral Di

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

2008

o completed cause of death (Item 23a) (Type, Print 478

31. Date filed (Month, Day, Year)

32, Registrar's Signature

Registrar DHMH 17 Rev 1/2001

Medical

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Erma I. Gladfelter 19,2008 anuary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner de 8. Date of Birth (Month, Day, Ye Nov. 23, . Age (In yrs. 9. Birthplace (State or Foreign Funeral Months Year) 1 ☐ M 2 🕱 F Days Hours Min. 192-32-2864 92 1915 Windsor Twp, PA Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at MD 1 ☑ Yes 2 ☐ No Har ford Havre de Grace Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 415 S. Market St. 21078 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: Specify: white Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) teacher education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alvin G. Strayer Bessie Waughtel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4047 Wilkinson Rd. Havre de Grace, MD 21078 Philip E. Gladfelter / son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bethlehem Stonepile
UM Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1/24/2008 Red Lion, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PA 1735 Burg Funeral Home, Inc 134 W. Broadway Red Lion chuf 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Commany diseuse Physician /Medical Due to (or as a consequence of): **Examiner** Mouransia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (br as a consequence of) Examine signed by the attending physician and the detached for use as the burial-transit amemia Physician/Medical MMMAM IF FEMALE: yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 100 +e1+en Erma vision or Vital Records, P.O. 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∏ Yes 2 No funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the I 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide or / thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Mhis fonth, Day, 31. Date filed (Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28 Year Physician KENNETH MELVIN SR. GLENN, JANUARY 2008 7:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21284 Chesapeake Ave. Rock Hall If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 9 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 M 2 □ F 73 Maryland 1934 214-32-5714 June Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 □ No Director MD Kent Rock Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21284 Chesapeake Ave. 21661 U.S.A. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify Specify: ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Groundskeeper Farm 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin Leon Glenn Mary S. Kelly ဂ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth M. Glenn, Jr. (son) 21290 Chesapeake Ave. Rock Hall, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kent Cremation 1/29/08 Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) 21. Significia et Juneral Se vio a Licensee 22. Name and Address of Facility Galena Funeral 118 West Cross L Schaech 21635 Home of Stephen St. Galena, MD. M00510 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in deat Physician nuone Porta 1 year /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1☐ Yes 2☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☐ Yo 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Inpatient this Certification: To 5 Nesidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) funeral Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 D Naturai 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) UD17030 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

2008

Susan K. Ross, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

516 Washington Ave.

Chestertown,

MD.

Physician /Medical Examiner attending physician and for use as the burial-tran P.O. Box 68760,

Department of Important: If it any Injury or o

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Certification:

Medical

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland enert of Health and Mental Hyglene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show mix: If item 27 is marked other than "natural", or items 25a or 28a-f show mix: If item 27 is marked other than "matural" or other than mast be notified at my or other than mast be notified at

Baltimore, Maryland 21215-0036

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s that the death certificate be executed

1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number D0031563 January 15, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles M. Benner, MD 10801 Lockwood Dr. # 205, Silver Spring, MD 20901 32. Registrar's Signat ORIGINAL

15

31. Date filed (Month, Day, Year, State **JAN 17** Registrar

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and ti

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 00

Certificate of Death

		Registi
	1. De	cedent
hysician		
/Medical		

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physici		Norman Sterling Gesell Norman Sterling Hesell Norman Sterling Gesell Norman Sterling Gesell Norman Sterling Gesell													
/Medic Examin		4a. Facility Name (If not institution, given Carroll Lutheran	ve street and cumper). Village	street and europe Village Center				Location of		<u> </u>	13, 2008 8:20 p 4c. County of Death Carroll				
Funeral Director			Sex 7. Ag 1 ☑ M 2 ☐ F	7. Age (In yrs. last birthda			1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Jun 3,	Year) 1923	9. Birth Cou	Birthplace (State or Foreign Country) [aryland		
Aaryland f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Carro.	11	, Town or	n or Location 10d. Inside C Westminster 1½ Yes										
with the Page or 28a-	i Direct	10e. Street and Number 1200 Long Valley		10f. Zip	Code	2115	8	-1	10g. Citizen of What Country? USA						
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "netural", or Itema 23a or 28a-f show simportant: if Item 27 is marked other then "netural", or Itema 23a or 28a-f show shy injury or other traumatic event, I'm Medical Examinar must be notified at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 1 Yes 2 1 If Yes, Give Year or Dates:			I. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 ☑ No Specify:					No- 14. Race - American Ind Black, White, etc. Specify: white				
within 72 ho ane. then "netur the Medical	Completed by	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	(G lif	ecedent's Usua live kind of wo le. DO NOT us hippind	rk done d se retired	luring most)		g	16b. Kind of Mani		ess/Industry				
id be filed ental Hygic ked other ic event, II	To Be Co	17. Father's Name (First, Middle, Las John Henry Ges			<i>y,</i>	18. Mother	's Name	(First, Middle, Eva Au	fle, Maiden Surname)						
nd 2 shou alth and M 27 ie mar r traumat	-	19a. Informant's Name/Relationship (Type, Print) Dr. Carol G. Dorsey, daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 1200 Long Valley Road, Westminster, MD										vn, State, Zij , MD 2	² Code) 21158		
Pages 1 a nent of Hei int: if item iry or oths		20a. Method of Disposition 1 Burial 2 Cremation 3 (4 Donation 5 Other (Spec		Số Ca	lace of Di SUCTY, C rrol	sposition (Nar crematory or c 1 Crema	ne of other place	e) 1		²⁰⁰⁸	20c. Locatio Winf	n-City or⊺ ield,			
permit. Departrimporta eny inju	Completed by Physician/Medical Examiner	21. Signature of Funeral Service Liga	Sulo		5					ers-Durk Vestmins					
Physician /Medical Examiner		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between the Mode of control of the Interval Between the Interval B													
death certificate be executed a attending physician and dror use as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d													
o o		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (<i>specify</i>)					23d. Date of delivery Month Day Year						
n requires that the de been signed by the should be detached		4 Cive- of the 20											the cause of death?		
The law rec				<u> </u>	-	-				24a. Whas autop perfor	sy	b. Were aut prior to co death? 1 Yes	topsy findings available ompletion of cause of		
cian: ertifica ector,	Be	25. Was case referred to medical examiner? Hospital:													
Physic this craft dir	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	ER/Outpa 28b. Tim	atient 3 Do	JA	4)Z Nui		Home 5 ☐ Residence 6 ☐ Other (Specify)							
Attending death. ctor: After y the fune	Certification	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not	Inju	ury Work? M 1 ☐ Yes 2 ☐ No			10	28f. Location (Street and Number or Rural Route Number,							
To the Hoepital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the completely filled in by the funeral director, page 2 should be detached.	al Certifi	29a. Certifier (Check only) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Rural Route Nu											stated.		
To the h within 24 To the F complete	Medical														
WILL		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Kup 295 Stones Hue St 397 Westmuste MD 21157													
	ate	31. Date filed (Month, Day, Year)	29 S G +	rar's Signa	ature	10 St 3	91	We	Str	nste	(VII)	2115			

5. Sparke

DHMH 17 Rev 1/2001

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 0529 A Graham 2008 Wanner 01 Maurice 15 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Medical Center egional If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yea. 9/16/1917 Funeral Months Days 1 M 2 □ F Maryland 90 215-18-4357 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 □ No "natural", or items 23a or 28a-f sh idical Examiner must be notified Director Salisbury Wicomico Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 21804 USA 139 Onley Road Funeral 14. Race · American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 □ No If Yes, Give Year or Dates: Army 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natu any Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) senior shipping clerk pump manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Anderson Alvin Peter Graham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 139 Onley Rd., Salisbury, MD 21804 Emma F. Graham/wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wicomico Memorial
Park Pages 1 a Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 NOther (Space) 1/18/08 Salisbury, MD 21. Signature of Funers Service Live 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 28a. Part 1. Enter the disease, or complications that a sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a h line. Immediate Cause (Final disease or condition resulting in death) Anyo cudial Intarction **Physician** /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of) Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: use a 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 🔲 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient ER/Outpatient 3 DOA မှ After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O.

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A filled in by

> State Registrar

29b. Signature and title of certifier

and manner stated

29c. License number DHOTIS

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E. Carrollst. Salisbury, mo 21804 P.R.M.C Hearne MD

31. Date filed (Month, Day, Year

29a. Certifier (Check only one)

> 16 JAN



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				1 - For State Registrar			of Ma	arylan		artmen rtificat)		Reg. No.	000	8	027	15	
		Physici /Medic		1. Decedent's Name James	Edwar		ffin							2. Date of De Month Janua	cy l	Day Yeer 3. Time of Dea 13, 2008 12:56			Р	
		Examin	er	4a. Facility Name (If I	GENERA	AL HOSP				4b. City, Town, or Location of Death BERLIN					V	4c. County of Death WORCESTER				
56		Funeral Director		5. Social Security Number 216-64-9693 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Months Days								If Unde Hours	Min.	8. Date of Bir (Month, Da 11/27/	3irth 9. 8 Day, Year) 9. 8 /1955 M			ace (State or I ry) yland	Foreign	
3		the Maryland 28a-f ehow notified at	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Wicomico Willards											10	od. Inside City				
150		with the M or 28a-f	Direct	10e. Street and Numl	LITALU	10f. Zip	Code				10g. Citizen of What Country?									
17		s 1 and 2 should be filed within 72 hours after death with the Maryland Heelth and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23s or 28s-1 ehow other traumatic event. The Medical Examiner must be notilised at	Funeral Director	36640 Old Ocean City Rd. 11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑					S. 13.		874 dent of Hi cify Cuba	ispanic O In, Mexica	rigin? (Spec an, Puerto F	cify Yes or No Rican, etc.)		JSA 14. Race Black, 1				
1/13/08	-0036	72 hours aft natural', or alcal Exemi	þ	3 🗷 Widowed 4		If Yes Year	1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates: In the second of							16b. Ki	Specify: white b. Kind of Business/Industry					
Ξ	21215	l within 72 iene. r than "na he Medic	Completed	(Specify Elementary/Second	y o <i>nly high</i> es	t grade complet	ed) ge (1-4or 5	+)	(Give	kind of wo DO NOT u	rk done d se retired	during mo l)	st of working cler			·				
200	land 2	s 1 and 2 should be filed within if Heelth and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me	To Be C	17. Father's Name (F								18. Moth	ner's Name	(First, Middle	, Maiden	th Lewis or Town, State, Zip Code) ards, MD 21874				
	Mary	nd 2 shou lith and M 27 is mar r traumati	-	19a. Informant's Nar Paul F. (me/Relationsh	nip (Type, Print)	other													
DOIS: 11/27/55	Baltimore, Maryland 21215-0036	ages 1 ar ant of Hee nt: If Item: y or other		20a. Method of Dispo 1 X Burial 2 4 Donation 5	Cremation		om State	Oal	lace of Disposition (Name of emetery, crematory or other place) K Hall Riverside 1/16/08						20c. Location - City or Town, State Libertytown, MD					
13.	Baltir	permit. Pages Department of Important: If It eny Injury or c		21. Signature of Fun				C	emeter 2	HOIIC	nd Addres	Fune Hill	ral H	ome Pro	ofes	siona.	L As	sociat	ion	
DO C		Physician		23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	tfailure. List i Final	complications to	nat caused on each lin	the death								m		Approximate Interval Betwee Onset and De		
	1	/Medical Examiner	J.		ditions.	b. Due	Col	a conseq	uence of):											
3	_	ate be executed by sician and the burial-transit	Ical Examiner	Sequentially list conditions, leading to immicause. Enter Undert Cause (Disease or in that initiated events resulting in death) La		c	to (or as										-			
9693	38760,	icate be e physiciar s the buria	173	la .		d		• •												
- トットー	P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Me										:	23d. Date of delivery Month Day Year			∌a r			
55# 316-64		uires that the signed by												acco use contribute to the cause of death?						
E SS	of Vital Records,		Completed		au pe								24a. Was auto perfe 1 ☐ Yes							
	F Vita	sician: certific rector,	To Be (25. Was case referred examiner?		Hospital:	X Inpatie	ent 2	ER/Outpatie	nt 3 🗆 D	Oth Oth	05		Check only		ence 6 Other (Specify)				
James	ion of	ding h. Aftel fune		27. Manner of ath 1 Natural 2 Accident	5 Pendin	g (/	ate of Injui Month, Day	ry y Yea <i>r)</i>	28b. Time o Injury	f M	28c. Injur Wor	yat k? Yes 2[28d. Describe	how injur	y occurred				
building, etc. (Specify)								2	28f. Location (Street and Number or Rural Route Number City or Town, State)											
29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man (only one) (one) (
9		To the To the comple	×	29b. Signature and t	title of certifier	\mathcal{L}		110		29	c. Licens	5 8	5		29d. Da	te signed (/	Month, i	Day, Year)		
299		10 Al		30. Name and addre	ss of pe on	rella	473	3/	Ica /1	1wan		hill	0 13	eclin	M	0 2	181	(J	
E		Sta Registi		31. Date liled (Month	Jan Keari	6 2008 ³	2. Registra	ar's Signa	lure	Sec.	مد		,							
14	DH	MH 17 Rev 1/2	001							*					- 10:	117				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician JANUARY 26, 8:45A JOSEPH HENRY HILDEBRAND 2008 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Funeral 1**X** M 2□ F 79 Director 214-30-1999 Oct. 1, 1928 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f sh notified 1 ☐ Yes 2 No Funeral Director Carroll Maryland Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 19 Phillips Lane 21791 Pages 1 and 2 should be filed within 72 hours after death item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) truck driver 11 petroleum products 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gary Roger Hildebrand Virginia Biddinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Virginia Hildebrand/ wife Union Bridge, MD 21791 19 Phillips Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 1/28/2008 | Sykesville, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signatura of Foneral Service Licensee atton 404 S. Main St. Woodsboro, MD 21798 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cardiac disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is listed as our injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi that initiated events and resulting in death) Last Due to (or as a consequence of): Physician/Medical the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) a∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760, or Attending after death.

I Director; Ald in by the fur within 24 hours af To the Funeral D completely filled i Hospital

2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

66276

Ty Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29b. Signature and title of certifier

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CORPORATE BLUD SVITE LOW, ROCKVILLE, MD 20850 9210

SHAN-E-ALI 31. Date filed (Month, Day, Year) State Registrar

Medical



10

State Registrar

DHMH 17 Rev 1/2001

2435 West Belvedere Avenue, Baltimore Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#Spital 24 32. Registrar's Signature

Sinai

PETER W. (Ho

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Rosalie May Henry 2008 28 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tarre Grace de 5. Social Security Number If Under 1 Year Hrs. 8. Date of Birth (Month, Day, Year) 7/13/1911 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2**X** F 494-20-8861 96 Director Iowa Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show a or 28a-f sh 1 Yes 2 No Harford Director MD Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a o iner must be 818 Matthews Avenue 21001 Funeral U.S.A.

14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify. Specify: þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dental & Nurses Assistant Medical 12 Department of Health and Mental Hygis Important; If item 27 is marked other any Injury or other traumatic event, <u>th</u> once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Sweeney Cora Rogers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21001 818 Matthews Ave. Aberdeen, Maryland Virginia Jacobs (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Gdns. 2/2/08 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring—Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licensee 21001-3399 Aberdeen, Maryland 23a. P. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** arrey LATENAM /Medical (or as a contequence of): Examiner Pain Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed obtodivesis physician and s the burial-tran Division or Vital Records, P.O. Box 68760、な Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27, Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural within 24 hours area we to the Funeral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28/18

State Registrar 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

whilm

31. Date filed (Month, Day, Year) FEB 0 1 2008

		For State Registrar	State of	Marylan			of Health		lental Hyg	iene	2000	0272
		Decedent's Name (First, Middle,	Last)						2. Date of Dea	th	<u> </u>	3. Time of Death
nysicia		Haro1d	George H	ubachek					Month 1 /	13/2	2008 Year	10:15 a
Medic xamine		4a. Facility Name (If not institution,				4b. City, T	own, or Locatio	n of Death			County of Death	
	76	Woodside Center	•			Silve	er Spri	ng		Mor	ntgomery	7
neral		5. Social Security Number 6		7. Age (In yrs.	last birthday)		Year If Und		8. Date of Birth	Year)	9. Birth	place (State or Forei
ector		539-40-8969	1 ∑ M 2□F	64	Yrs.	Wiching	Days	IVIII I.	7/19/19			oma, WA
		Usual Residence of Decedent		10- 0								10.11.11.00.11.11
ig i	_	10a. State 10b. County		Tuc. Cit	y, Town or Lo	cation						10d. Inside City Limit 1 XYes 2 ☐ N
tifie	cto	MD Montgo	mery	Sil	ver Sp	ring						
oe no	Director	10e. Street and Number				10f. Zip 0	Code		1	0g. Citiz	en of What Cou	ntry?
tsm		10944 Rocky Mou				2090					5.A.	
any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status	Armed For		.S. 13. \	<i>N</i> as Decede If Yes, speci	nt of Hispanic (y Cuban, Mexic	Origin? (Spe can, Puerto	ecify Yes or No- Rican, etc.)	1	 Race - Americal Black, White, 	
amir	by F	1 Never Married 2K Marrie	If Yes Giv	6		1 ☐ Yes 2	No <i>Sp</i> eci	fy:			Specify:	
Ex		3 Widowed 4 Divorced		ites: 1963						101 10		nite
gica	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual kind of work	done durina m	ost of work	ing	16b. Kin	d of Business/Ir	ndustry
e Me	шp	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT use	. '			~		D * .
된		17. Father's Name (First, Middle, La	6		Syste	ms Ana		hor's Name	(First, Middle, i		rnment/	Private
evel	Be		,						•		ourname)	
atic	မ	Ernest Hubachek							Schne1			
raum		19a. Informant's Name/Relationshi							al Route Number			,
hert		Mary Q. Hubache	k, Wife	001 5					, Silver			
or of		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	B∏Removal from S		Place of Dispo cemetery, crei	isition (Name matory or oth	e of ner place)	L	Date	20c. Loc	ation - City or T	own, State
d'i		4 □ Donation 5 □ Other (Spe			tropoli	itan C	remator	y 1/	14/2008	A1	exandria	a, VA
any inj once.		21. Signature of Funeral Service Li	censee	D &	22	2. Name and	Address of Fac	cility		47	'39 Balt	imore Ave
등등		ros	-W. ()	MIT	MAL Ga	sch's	Funera:	1 Home	e, P.A.	Hy	attsvil	le, MD 20
	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):	hlor	ally.					
for use as	Physician/Medical	IF FEMALE: N N N 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 ☐ Feta ant at time of c	al death 3]Ectopic pre] Other (s <i>p</i> e				23	3d. Date of deliv Month	rery Day Year
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age 2 sho	Completed								24a. Was a autops perform	n <u>ed</u> 2	prior to co death?	opsy findings availab ompletion of cause o
or, p	0	25. Was case referred to medical					26 Ple	on of Death	1 Yes h (Check only on	2\2\No	1 ☐ Yes	2 □ No
rect	m	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2	ER/Outpatier	+ 3□ DO4	Othor	_			DOther (Creek	***
ald	5	27. Manner of Death	28a. Date o	of Injury	28b. Time of		c. Injury at Work?		me 5 Reside			119)
Î,	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		h, Day Year)	Injury	М	Work? 1 ☐ Yes 2	∏No				
completely filled in by the funeral director, page 2 s	Certification:	3 Suicide 6 Could no determin	t be 28e. Place	of injury - At hong, etc. (Specil		eet, factory,	office		28f. Location (Si City or Town		Number or Rur	al Route Number,
oletely fille	Medical (29a. Certifier 1 Certifying (Check only one)	Physician: To the kaminer: On the ba and mann	asis of examina	owledge, death ation and/or in	n occurred a vestigation,	t the time, date in my opinion, d	and place, leath occur	and due to the c red at the time, c	ause(s) a	and manner as place, and due	stated. to the cause(s)
comp	Ž	29b. Signature and title of certifier	4			29c.	License numbe	r	2	9d. Date	signed (Month)	, Day, Year)
-		1. an	lian			121	49646	775		i	1141	?
_ 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
3	}	30 Name and address of porson	ho completed cause	of death (Itan	n 23a) /Typo	Print)					,	
5			nal MD ~			,		Cnvi-	ng,MD 20	Q10	,	

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** January 4:22AM *8*[3008 PHYLLIS \mathtt{MALIE} HILL4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FAHRNEY-KEEDY MEMORIAL HOME BOONSBORO WASHINGTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | NOWnth, 30, Year) 923 7. Age (In yrs. last birthday) 84 yrs. 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number CWIARYLAND 1 □ M 2 🕅 F 214-36-2242 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2X No Director MARYLAND | WASHINGTON BOONSBORC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21713 8507 MAPLEVILLE ROAD U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. þ Specify 3 Widowed 4 □ Divorced WHITE Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ COUNTY BOARD OF ED ADMINISTRATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GEORGE A. SITES MAMIE C. FUNKHOUSER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CHRISTINE A. STOOPS, DAUGHTER 5633 MT. CARMEL CHURCH ROAD, KEEDYSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ST. PAULS CEMETERY 1/21/2008 CLEAR SPRING, MARYLAND 5µ□ Other (Specify) 4 ☐ Donation 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7606 OLD NATIONAL PIKE BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 ECOTY-DEVICE

Team cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. P.Int. E. Jert V. disease, sock, o hear failure. List only Immediate Caus. (Final disease or condition resulting in death) Approximate Interval Between Onset and Death D cardiorescular Viscose extensine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its lead as each to the condition of the cause of the caus Due to (br as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Hospital: 1 ☐ Yes 2∰No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

Examiner burial-tra Box 68760 the attending phase as the ached for use P.O. Records, Vital Physician: 9 Division Hospital or Attending within 24

/Medical

Funeral

Director

ral", or Items 23a or 28a-f sho Examiner must be notified at

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Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth any Injury or other traumatic event

Physician /Medical

Medical

with the Maryland

death 1

filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D12323

29d. Date signed (Month, Day, Year)

1/18/2008

			For State	State of Mar			tment of H		nd Men		71115	02722
	100	, sp	Registrar Decedent's Name (First, Middle, Last)				modito of E	Journ		Date of Death		3. Time of Death
W.	Physici /Medic		Roland W.Haney							Month $an.13.2$	Day Year	1639p. M
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4	4b. City, Town, or	Location of D			4c. County of Dea	
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	Funeral Director		5. Social Security Number 6. Sex	/. Age ((In yrs. last birt		If Under 1 Year Months Days		Min. T	Date of Birth Month, Day, 1 n. 7, 19	Year) 9. Bi	rthplace (State or Foreign country) Ch Carolina
ų ,			Usual Residence of Decedent		0 1				00	111. / , 1.	724 pout	III Galolina
	irylan ihow I at	_	10a. State 10b. County		I0c. City, Town							10d. Inside City Limits
	8a-f s	Director	MD. Prince Ge	eorges	Capita	1 He						1 ☐ Yes 2 No
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	ns 23	Funeral	6305 Field Street 11. Marital Status	2. Was Decedent Eve	er in U.S.	13. Wa	20743		n? (Specify	Yes or No-	U.S.A.	erican Indian,
ယ	filed within 72 hours after death with the Maryland Hygiene. Hygiene. then "natural", or items 23a or 28a-f show ther than "natural", or items 23a or 28a-f show ant, the Madical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □XYes 2 □ No If Yes, Give			as Decedent of Hi es, specify Cuba		Puèrto Rica	n, etc.)	Black, Whi	
ğ	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:19	43-45	11	Yes 2 No	Specify:			Specify: B1	Lack
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/la	urid be Menta Irked Itic ev	To B	Tom Haney					Selin	na Lit	tlejoh	ın	
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Typ	e. Print)	19b.	Mailing .	Address (Street a	nd Number o	or Rural Ro	ute Number,	City or Town, State,	Zip Code)
	1 and Health em 27 other tra		Henrietta Haney (V	Vife)					al He		MD.20743	T
00.	Pages nent of hant: If ite		MXBurial 2 □Cremation 3 □Re				ion (Name of tory or other place	1			0c. Location - City o	,
altimore,	permit. Page Department of Important: If any Injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		Cheffer		Vet.Cem		-24-08		neltenham,	, MD .
ä	permit. Departr Importa any Inju		Aprillis Be	US			Name and Addres				cal Home 1.VA.22314	4
į.	76		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the cause on each line.	e death. Do n							Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	Fatal C		Arr	hvthmia					Onset and Death
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ō	his his	5 T	1 Yes 2X No I'' 27. Manner of Death	1 XInpatient 28a. Date of Injury	2 ER/Out 28b. T	·	OLI DOX	4 🗀 Nursii			ce 6 Other (Specification)	ecify)
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DIVISION	Attend er death. rector: / by the fi	tifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury building, etc. (- At home, far	m, street	t, factory, office			ocation (Stre		Bural Route Number,
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1	e 4 1 5	Medical	29a. Certifier 1	ician: To the best of r er: On the basis of ex and manner stated	xamination and	, death o d/or inves	ccurred at the tim stigation, in my op	e, date and pointion, death	place, and o occurred at	due to the cau t the time, dat	use(s) and manner a te and place, and du	is stated. ue to the cause(s)
4	vithin 24 h	Me	29b. Signature and title of certifier	1			29c. License	number		290	d. Date signed (Mon	nth, Day, Year)
1	6) I UA		10	two	all.		D589	57		J	Tan.17,200)8
ال	ge		30. Name and address of person who con		, , ,		,	0	. M	0705		
	Sta	te	Gary Little 31. Date filed (Month, Day, Year)	32. Registrar's		ртса.	1 Dr.,Ch	everiy	, PID . 2	.0/03		
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 14, 2008 **Physician** 10:30 AMM Esther Jorolan /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 7401 New Hampshire Avenue#909 Takoma Park If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Month, Day, Year) June 4, 1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Philippines Months Days Hours 1□M XXF 84 261-58-6250 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. Count Ahow r than "natural", or Itema 23a or 28a-f ahov the Medical Examiner must be notified at 1X Yes 2 □ No Montgomery Takoma Park Maryland | Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20912 U.S.A. 7401 New Hampshire Ave., # 909 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: SpecifAsian þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Research Scientist/Army Hospital Government +5 Ith and Mental Hygie 27 Is marked other r traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Feliciana Plaza Valentin Jorolan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) partment of Heelth a sociant: If Itam 27 is / Injury or other trace 11107 Mountain View Lane, Ijamsville, MD 21754 Mr. Glennon J. Wilhelm, Friend Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 24 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Pages 1 Smithsburg Crematory Jan. 30, 2008 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²² Keeney and Basford PA Funeral Home MD -21701 MOO255 106 East Church St., Frederick, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attanding Physician: The law requires that the death certificate be executed physicien and the burial-transit Division of Vital Records, P.O. Box 68760 $\mathcal{F}_{\mathcal{L}}$ Due to (or as a consequence of): Physician/Medical 98 IF FEMALE: USB 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year ö 5 ☐ Other (specify) 4☐Pregnant at time of death signed by tha a d be detached f 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ል 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 □ No director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 3 DDA this After this funeral of 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Injury at Work? 5 Pending investigation efter death. 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funeral C completely filled i Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and grapher stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Dav. Year) 29c. License number Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2121 medical $\mathcal{Q}_{,}$ BRECKER mo 2. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Nellie C. Jackson 2008 /Medical January 11, 6:59 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Frederick Calvert Memorial Hospital Calvert If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 X F Director 217-32-0406 MD February 10, 1930 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show a or 28a-f sh Director 1 □Yes 2 No MD Calvert Prince Frederick 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? with items 23a c Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mohal Hygiene.
ant: if tiem 27 is marked other than "ratural", or items 23; ury or other traumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must by Funeral USA 90 Mason Road 20678 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Joseph Morris Lydia Mason 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Jackson - Daughter 90 Mason Road, Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Cheltenham Veterans Cem. 1/24/2008 Cheltenham, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Blady 4. Sewell Funeral Home, 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ATHEROSCLEROTIC Immediate Cause (Final DISEASE years HEART **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is introduced as on the cause of the ca Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last as the burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregpant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of 24a Was an death? 1 ☐ Yes 2 ☐ No 1∏ Yes 2 [V No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 1 🔲 Inpatient 27. Minney f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director; Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

dew 5

31. Date filed (Month, Day, Year) State JAN 1 1 2008 Registrar

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed suse of death (Item 23a) (Type, Print)

Munshi

Prince Frederick, MD 20678

29d. Date signed (Month, Day, Year)

29c. License number

			1- State of Marylan State of Marylan		artment of Hea			ene . No. 2008	02725
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
1	Physic /Medi		Michael Edward Keplinger				January	^{Day} 15,2008	9:10p M
not.	Exami	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc	cation of Death		4c. County of Death	
	<u> </u>	-	39 Pine Bluff Lane 5. Social Security Number 6. Sex 7. Age (In yrs.	(as t hirthday)	E1kto		0. Data at Birth	Ceci1	
	Funeral Director		221-60-8585 15M 2 F 35	Yrs.		lours Min.	8. Date of Birth (Month, Day, Yo October	(ear) 9. Birthpl Count 27, 1972	ace (State or Foreign try) DE
	PL ,		Usual Residence of Decedent				occoper	. 21,1912	DE
	with the Maryland a or 28a-f show	'n		y, Town or Lo				10	Od. Inside City Limits
	the M 28a-f notifie	Director	MD Cecil 10e. Street and Number	E1kto					1 ☐ Yes 2 ZNo
	3a or		39 Pine Bluff Lane		10f. Zip Code 219	21	10g.	. Citizen of What Count	*
	death ms 2 r mus	Funeral	11. Marital Status 12. Was Decedent Ever in U.	S. 13. V	Was Decedent of Hispa f Yes, specify Cuban, N		cify Yes or No-	14. Race - America	
9	after or Ite		1 ☐ Never Married 2 【X Married 1 ☐ Yes 2 X Moorling If Yes, Give		t Yes, specity Cuban, N I□Yes 2 € No <i>S</i>		Rican, etc.)	Black, White, e	
9	within 72 hours after death with the Maryland ene. than "natural" or Items 23a or 28a-f show he Medical Examiner must be notified at	d by	3 Widowed 4 Divorced Year or Dates:					Specify: Whi	Le
15	in 72 i "nat ledica	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupatior kind of work done durin DO NOT use retired)	n ng most of workin	g 16i	b. Kind of Business/Ind	ustry
212	d withir jiene. r than the Me	mo	Elementary/Secondary (0-12) College (1-4or 5+)	<i>mo.</i> 2	Carpent			Construct	tion
bu	be filed within 7 ital Hygiene. id other than "n event, the Med	BeC	17. Father's Name (First, Middle, Last)				(First, Middle, Mai		
ylai	2 should be and Menta is marked aumatic ev	To	Danny E. Atwell		J	eannie	Keplin	iger	
Maryland 21215-0036	2 sho	- 11	19a. Informant's Name/Relationship (Type. Print)	1				ity or Town, State, Zip	Code)
	1 and Healtl em 27 ther t		Jeannie Keplinger/Mother 20a. Method of Disposition 20b. P		Pine Bluf				1921
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic evonce.				sition (Name of natory or other place)	Janu	arv	c. Location - City or Tov	•
Ħ	nit. P artme ortan injur	(6)	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Servic Censee		Cemetery Name and Address of	19,2	008 0	pper Trac	CK, WV
ä	Dep lmp any	l y	interest	1	Andrew G.	Gée F	uneral		
4	304		23a Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ente	259 E. Ma er the mode of dying, su	ich as cardiac or	, Elkto respiratory arrest,	n, MD 2	L O 2 1 Approximate
×,	Physician		disease or condition		riomy				Interval Between Onset and Death
	/Medical Examiner		resulting i death) a. Due to (or s a consequ	ence of):	LUMG				mc. shs
	LXammer	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequ						
	ted nsit	Examiner	Cause. Enter Underlying Cause (Disease or injury	ence of):					
<u>,</u>	execunand and ial-tra	Exar	that initiated events resulting in death) Last C	ence of):					
8760,	cate be executed oblysician and the burial-transit	dical	d						
യ	rtifica ng ph	Medi	IF FEMALE.						
Box	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnant □ Live birth 2 □ Fetal		Ectopic pregnancy			23d. Date of deliver	·
<u>.</u>	the a	/sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of de 9 ☐ Unknown		Other (specify)			Month E	Day Year
۳.	w requires that the di been signed by the should be detached	P.	Part II. Other significant conditions contributing to death but not resu	Iting in the un	derlying cause given in	Part I	23e Did tobacc	co use contribute to the	sound of death?
ds	luires 1 sign 1d be	d b				,	N	2 No 3 Proba	
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ř	: The law cate has page 2 s	Completed					autopsy performed	prior to com death?	sy findings available pletion of cause of
Vital Records, P.O.	sician: The certificate rector, pag	BeC	25. Was case referred to medical examiner?		26.	Place of Death (1□ Yes 2 X	No 1 □Yes 2	No
<u>></u>	Physic this ce al direc	2	Hospital:	R/Outpatient	Othori			e 6 □Other (Specify)	
Ĕ	ding Pł h. After tł funeral		1 Natural 5 □ Pending (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		d. Describe how in		
<u> </u>	death death stor: / the /	cat	2 Accident investigation 3 Suicide 6 Could not be	ma form other	M 1 ☐ Yes				
DIVISION OF	after Direction by	Certification:	4 Homicide determined 28e. Place of injury - At hor building, etc. (Specify,	le, iami, stree	ет, тастогу, опісе	28	f. Location (Street City or Town, St	t and Number or Rural i tate)	Route Number,
			29a. Certifier 1 Certifying Physician: To the best of my know	ledge, death	occurred at the time, da	ate and place, an	d due to the cause	e(s) and manner as sta	ted
	he Ho In 24 I he Fu pletel	edical	(Check only and manner stated.	on and/or inve	estigation, in my opinior	n, death occurred	at the time, date	and place, and due to t	he cause(s)
	To the total	Ž	29b. Signature and title of certifier		29c. License num	nber	29d. I	Date signed (Month, Da	ay, Year)
			H. Jorkin MD		13153	14	Je.	nuay 16.	lais
	2		30. Name and address of person who completed cause of death (Item :	23a) (Type, Pr	rint)			22:	
	Stat	0	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	is Ho	spice 13	33 N. 1.	Bridge.	ST Elkpin	Mo
	Registra	٠,	30. Name and address of person who completed cause of death (Item 2) 31. Date filed (Month, Day, Year) 32. Registrar's Signature of the state of t	1 da	Matrice 1				

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32 Registrar's Signature

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31. Date filed (Month, Day, Year)

HARERSTOWN MO 21740

			For State		State of	of Maryla		artment of H rtificate of I	lealth and N Death		0.0	000	00707
			Registrar 1. Decedent's Nam	ne (First, Middle,	Last)			timodic or i		2. Date of De	Reg. No.	LUO	3. Time of Death
	Physicia			EDWAR				LINDSAY		Month 01	25 2	Year 008	1645 M
	/Medic Examin		4a. Facility Name (ımber)			r Location of Death	U.L		ty of Death	11045
	Examin	<i>**</i>	WMHS-	-BRADDOC	K CAMPUS	;		CUMBERI	AND		ALLE	GANY	
	Funeral		5. Social Security N	Number 6	. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th v. Year)	9. Birthp	place (State or Foreign
	Director		215-20-	-6352	1 X M 2□F	81	Yrs.	Month Days	110010	FEB. 1			YLAND
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N .	Hygie Hygie Hert		17. Father's Name	(Eirst Middle L			KE.	SEARCHER	18. Mother's Nam	e (First Middle		ULES,	TIVC.
and	antal h	Be C		LINDSA	•					E GLAZE	,	,	
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ค์ .	S 1 a		20a. Method of Dis				b. Place of Dispo	sition (Name of matory or other place		Date	20c. Location	- City or T	own, State
֡ ֡ ֡	Page nt: 1f iry or			☐ Cremation 3 5 ☐ Other (Spe	B □Removal from ec <i>ify)</i>		SVC-ROCI		i	3/2008	FLI	NTSTO	NE, MD
Baltimo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. IDepartment of Health and Mental Hygiene. any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of F	uneral Service Li	censee	Ω	/ 22	2. Name and Addre	ss of Facility NERAL SEF				
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			23a. Par 1. Enter shock, or he	the disease, or c art failure. List o	omplications that by one cause on	caysed the deach line.	eath. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
_E F	hysician		Immediate Cause disease or condition	on	a.	Pulo	nouge	4/-11	110515				UNKHOWN
	/Medical Examiner		resulting in death)	-	Due to	(or as a cons							
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ם .	w requires that the death certific been signed by the attending I should be detached for use as	Physician/Me	in the past 12	□No		gnant at time		Other (specify)	,		ľ	Month	Day Year
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	n: The ficate ha		25. Was case refe						00 81 15	1□ Yes	2 No	1 ☐ Yes	2 □ No
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0	ding Physia. h. After this of funeral dire	I	27. Manner of Dea	ith	28a. Date	e of Injury	28b. Time o				how injury occ		.,,,
<u>.</u>	nding tth. r: Afte e fun	랿	1 Matural 2 ☐ Accident	5 ☐ Pending investiga		nth, Day Yea	r) Injury		Yes 2 □No				
noision	Afte er dea recto by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	~ 28e. Plac	e of injury - A	at home, farm, str ecify)	reet, factory, office			Street and Nur	nber or Rui	al Route Number,
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical	29a. Certifier (Check only one)		xaminer: On the				me, date and place opinion, death occu				
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)			1/1	wins		MAN	My	2 1) 5	>5/55		1/2	6/0	7 8
	12+1		30 Name and add	iress of person w	no completed car	use of death (Item 23a) (Type,	CoL.	2-17	inh	Wan	11	1/1
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	Registr	rar	F	EB 0 1	2008	Peres.	A	anti)					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 15, 2008 Michaela 11:52A.M Μ. Litts /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3052 Piano Lane Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Sept. 18, 1953 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F 54 New Jersev 152-44-6292 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Marvland Silver Spring Montgomery 1 ☐ Yes 2 No Iral", or items 23a or 28a-f sh Examiner must be notified Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3052 Piano Lane 20904 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∆ Yes 2 □ No If Yes, Give 1076±107 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: IT Yes, Give Year or Dates 1976-1976 à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Officer private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael F. Shard Agnes Eileen McMananan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3052 Piano Lane Silver Spring, Maryland 20904 Earl W. Litts -husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State cemetery crematory or other place)
Metropolitan Crematory 1/20/2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stroke /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【XNo 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) the ? signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 icate has been siç , page 2 should b 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No certificate After this certification, 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physician: To the Hospital

within 24 hours after death.

To the Funeral Director: Al 5

29a. Certifier (Check only one)

29b. Signature and title of certification

31. Date filed (Month)

Registrar DHMH 17 Rev 1/2001

State

Bruce Rind, M.D. 5225 Wisconsin Avenue, N.W., #401 Washington, D.C. 20015 32. Repistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D37186

29d. Date signed (Month, Day, Year)

January 16, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Regist/AMEND#18perFH1/22/08, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Vear 12:05PM Lewis Heven 4 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Maryland Medical Center

| 6. Sex | 7. Age (In yrs. last birthday, University of Baltimore
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 5/17/1952 Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last hirthday) Days Hours 1**X**M 2□F 55 Director 216-64-2975 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1XIYes 2□No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 10120 Kinross Avenue death v by Funeral 20901 U.S. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examine 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4+ Compensation Specialist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore G. Lewis ၉ Frances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Candace Lewis / Wife 10120 Kinross Ave., Silver Spring, MD 20901 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 0 4 ☐ Donation 5 ☐ Other (Specify) 1/17/08 Beltsville, MD Chesapeake Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician AML Due to (or as a consequence f): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No by the 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 1□ Yes 2 4No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No P 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After I completely filled in by the funeral 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 AU4176435618143 14,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Gai Street , Baltimore MD 2 Greene JAN Year) 7 31. Date filed (Month State 2008 Registrar

DHMH 17 Rev 1/2001

Barbara Larson-Dixon/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 18, injury e. Cedar Hill Cemetery 2008 21. Signature of Funeral Service Licensee 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Arteriosclerotic Cardiovascular Disease resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached to ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. Completed 24a. Was an performed? 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA ဥ 27. Manger of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide determined 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 758461 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) SPORN 1500 FOREST 31. Date filed (Month 32. Distrar's Signature State Registrar DHMH 17 Rev 1/2001 ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Month Louis Olin Larson 6:45 p^M 15, 2008 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 X M 2 □ F 390-18-2008 89 Oct. 1, 1918 Wisconsin Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 Tyes 2 XNo Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10713 Jamaica Drive 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1⊠Yes 2□No If Yes, Give Year or Dates: 1942–45 1 Never Married 2K Married 1 ☐ Yes 🎗 🔀 No 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Furniture Salesman Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Austin Larson Louise Dorothy Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21067 Calhoun Corners Terrace, #100, Ashburn, 20c. Location - City or Town, State Suitland, Maryland Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year) Jan 15, 2008 GLEN RD., SILVER SPRING, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Harley Russell Long Sr. 1525 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 8. Date of Birth (Month, Day, Year) February 26,1950 7. Age (In yrs. last birthday) 57 Yrs. 9. Birthplace (State or Foreign 1 X M 2 □ F Months Davs Hours Min Delaware 526-90-7815 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Cecil Conowingo Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Miller's Park Drive 21918 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 2 No 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plant Operations Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harley Francis Long Irene Ludlum 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna D. Long/Wife 4 Millers Park Drive Conowingo, Maryland 21918 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date R.T. Foard Funeral Home P.A. Rising Sun, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility R. T. Foard Funeral Home, P.A. Queen Street Rising Sun, Maruland 91911 23a. Rart1. Enter the dispase, or complication shock, or heart failure. List only one can that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresting Myscandial Immediate Caus final disease or core on resulting in death) basle Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Important: If item 27 is any injury or other trau

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or dical Examiner must be r

the Medical

Baltimore, Maryland 2121

Pages 1 and 2 should be nent of Health and Mental

The law requires that the death certificate be executed burial-tran use for detached page 2 should be certificate Physician: this

Division or Vital Records, P.O. Box 68760,

or Attending

after death

in by the funeral To the Hospital o within 24 hours aft To the Funeral Di

Examine Physician/Medical

ģ Completed Be Certification: To

ca

31. Date filed (Month, Day, Year) JAN 2 2 State

29b. Signature and title of certifier

2 Accident

3 ☐ Suicide

29a Certifier

4 ☐ Homicide

6 ☐ Could not be

2008

and manner stated.

29c. License number 110058570

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item, 23a) (Type, Print). Terrarce L. Beller Good Servaritan Hospital Baltinore 21239

32. Registrar's Signature FARLAS ...

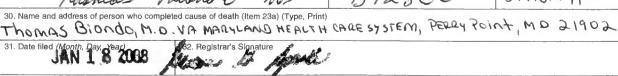
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

	ype or Print in Black Indelible Ink. Ensure A	
	State of Maryland / Department of Health and I Certificate of Death	Mental Hygiene
	Certificate of Death	Reg. No.
First, Middle, Last)		2. Date of Death

		for State Registrar	State of Maryland		rtificate of i		Reg. No.			
Physicia		Decedent's Name (First, Middle, Las FLOZELL I					2. Date of Deat Month JANUA	Day Year	3. Time of Death	
/Medic Examin		4a. Facility Name (If not institution, give	street and number)	= M	4b. City, Town, or PERRY	Point	n	4c. County of Dea		
Funeral		VA MARY LAND HEA 5. Social Security Number 6. Security Number	X 7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bii	thplace (State or Foreign ountry)	
Director		420–16–7593 Usual Residence of Decedent 10a. State 10b. County	87	, Town or Lo	cotion		NOV 20,	1920 A	LABAMA	
e Maryla 3a-f shov tified at	Director	MARYLAND HARFO		, TOWIT OF LO	ABERD	DEEN			10d. Inside City Limits 1 X Yes 2 □ No	
h with th		10e. Street and Number 1418 WILLSHIF	E DRIVE		10f. Zip Code	21001	11	0g. Citizen of What C USA	ountry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 💢 No		pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	te, etc.	
72 hour natural' dical Ex	eted b	15. Decedent's Edi (Specify only highest grac	Year or Dates: 1942—	16a. Deced	dent's Usual Occup		king	16b. Kind of Business	BLACK i/Industry	
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uld be file Jental Hy rked othe tic event,	To Be C	17. Father's Name (<i>First, Middle, Last</i>) HUBERT LEETH				18. Mother's Nan	ne <i>(First, Middle, N</i> VITTY	Maiden Surname)		
id 2 shoilth and N		19a. Informant's Name/Relationship (7)	/pe. Print)	19b. Mailing Address (Street and Number or Run 1418 WILLSHIRE DRIVE, A					,	
Pages 1 and nent of Health int; If item 27 iry or other tr		20a. Method of Disposition 1 Transport 2 Cremation 3	20b. Pt	ace of Dispo	sition (Name of matory or other plac	1	Date 20c. Location - City or Town, State			
permit. Pac Departmen Important: any injury once.		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service License	GARF		FOREST VE 2. Name and Addres	ss of Facility	28/08	OWINGS MI	<u>.</u>	
B a ji De		Plesa V	stt-Com				and the second s	P.A. DE GRACE,		
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. a	VA	er the mode of dyin	g, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death	
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quires that the de	۵	Part II. Other significant conditions co	ntributing to death but not resul	Iting in the ur	nderlying cause give	en in Part I.			o the cause of death?	
Physiclan: The law requir r this certificate has been si ral director, page 2 should	Completed						24a. Was ar autops perform 1 Yes 2	y prior to ned? death?	utopsy findings available completion of cause of	
ysiclar is certif director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🛣 Inpatient 2 🗆 E	ER/Outpatien	t 3 DOA Oth	ar:	th <i>Check onl one</i>	ence 6 □Other (Spe	acifu)	
ing Affe une	ertification: T	27. Manner of Death 1 M Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Hemicide determined	(Month, Day Year) 28e. Place of injury - At hor	28b. Time of Injury	M 1 □		28d. Describe ho	w injury occurred		
To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	OF	29a. Certifier 1 Scertifying Phy	building, etc. (Specify, sician: To the best of my know iner: On the basis of examinati	vledge, death	n occurred at the tir	ne, date and place	City or Town	, State)	s stated	
To the H within 24 To the Fi complete	Medical	29b. Signature and title of certifier	and manner stated.	and/or III	29c. License			ate and place, and du 9d. Date signed (Mon	th. Dav. Year)	
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31. Date filed (Month, Day, Year) 31. Da State



Registrar

42800

29d. Date signed (Month, Day, Year) JANUARY, 15 2008

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 7:20 AM EHL JANUARY 15 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner JOHNS HOPKING BAYVIEW MEDICAL CENTER BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) North Months Days Hours 1 XM 2 ☐ F Director 213-72-6163 16,1956 April Carolina Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 707 E. 41 Street 21218 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) dother than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Is marked Mayso Leak, Sr. Luenet Caple 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once. Jo Anne Leak Wife 707 E., 41 St., Baltimore, Md. 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 18, 2008 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Church Of The Lord Jesus Christ Ironsides, Maryland ^{22. Name and Address of Facility}
Williams Funeral Home, P.A.
4270 Hawthorne Rd., Indian Head, Md. 21. Signature of Funeral Sovice Licen M00668 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one caus —— ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condit in resulting in death) **Physician** HECKOTIC 5MML BOWEL 5 days /Medical Due to (or as a consequence of): Examiner CARDIOLYOPATH cars Sequentially list conditions, if any, leading to infractionate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dire to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by perforation 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Loronan 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ 1 Inpatient 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mentan JANUAR 15 205-000 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EMTELN AVENUE BALTIMORE MD A ALNOLD 31. Date filed (Month, Day, Year) State JAN 1 8 2008 Registrar Goods

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Lawrence Carl Miller, Sr. ам 1/15/2008 6:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner University Park Prince George's 4214 Van Buren St. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1X M 2 □ F Director 577-09-8756 91 10/28/1916 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☑ Yes 2 ☐ No MD Prince George's University Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 4214 Van Buren Street 20782 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 ☐ Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) U.S. House of Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Representatives s 1 and 2 should be filed w f Health and Mental Hygier ttem 27 Is marked other tt other traumatic event, the Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Lewis Miller Henriette Reichmann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Pages 1 and of Health and the notes of t Lawrence C. Miller, JR, Son 119 Timberbrook Lane #302, Gaithersburg, MD 20878 Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State <u>-</u> 5 Department or Important: If any injury or 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 1/17/2008 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or confidications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myelodysplastic Syndrome /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the dry frame Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Cardiomyopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy perform certificate 1 2**X** No Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 1 | Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural s after dec. cal Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide ō within 24 hours a 1½ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) D26207 January 16, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 7305 Baltimore Blvd., College Park, MD 20740 Michael Berard, MD . Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 JAN 1 7 Registrar

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Of Ma		Department of Health a Certificate of Death	and Mental Hy	-50 -50	08 02735
	Physici	an	Decedent's Name (First, Middle, Last)	-		2. Date of D		3. Time of Death
8/	- /Medi		Hubert Calvin Mentz			Janua	ry 6, 2	008 10:10 AM
	Examir	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of	of Death	4c. County	
- Ac.	Funeral		Union Hospital of Cecil Cou 5. Social Security Number 6. Sex 7. Age	inty e (In yrs. last birt	Elkton hday) If Under 1 Year If Under	24 Hrs. 8. Date of B	irth	ecil 9. Birthplace (State or Foreign
	Director		234-24-6552 ^{1፟} ፟፟∭™ ² □F	85	rs. Months Days Hours	Min. (Month, D	28,1922	9. Birthplace (State or Foreign Country) Virginia
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	Maryla f sho ied at	o						1√ Yes 2 No
	r 28a-	Funeral Director	Maryland Cecil 10e. Street and Number	E1k	10f. Zip Code		10g. Citizen of V	What Country?
	th wit	al D	302 Skipjack Court		21921		United	States
	tems	nuel	11. Marital Status 12. Was Decedent E Armed Forces?		13. Was Decedent of Hispanic Ori	gin? (Specify Yes or N i, Puerto Rican, etc.)		e - American Indian, ck, White, etc.
36	irs afte	by F	1 ☐ Never Married 2X Married 11 ☐ Yes 2 ☐ N If Yes, Give 1	942-45	1 ☐ Yes 2 ☑ No Specify:		Specify	White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	ted	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occupation		16b. Kind of Bu	usiness/Industry
2	ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12) College (1-4or 5-	+1 .	(Give kind of work done during mos life. DO NOT use retired) uto Mechanic	t of working	II C C	
2	Hygiel Hygiel ther th		5 17. Father's Name (<i>First, Middle, Last</i>)	A		er's Name <i>(First, Middle</i>	J	vernment
Maryland	should be and Mental somewheal somewheal or somewheal or sumartic ever	To Be	Grover Cleveland Mentz			lie Kellev	s, Maideri Surriari	ie)
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Street and Number		ber, City or Town,	State, Zip Code)
	and 2 ealth a n 27 is		Geneva D. Mentz / Wife		2 Skipjack Court	, Elkton, 1	Maryland	21921
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition Wear Survival 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of cemeter	Disposition (Name of y, crematory or other place)	January	20c. Location -	City or Town, State
Ħ Ħ	2 a ti 5	i	4 Donation 9 Other (Specify) 21. Signature of April 20 rules rules and a second	E1kton		11, 2008	Elkton,	Maryland
Ba	permit. Departm Importal any Inju		V Bell		22. Name and Address of Facility 127 South Main			
	d:		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause in each lin	the death. Do n				Approximate
	Physician		Immediate Cause (Final disease or condition	ronto	21			Interval Between Onset and Death
	/Medical Examiner		resulting in death) ue to or as a	consequence	1 In Cong &	ma		hour
	<u>#</u> 611-	er	Saquemally list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	a consequence of	n many	Ny		1000
5	cuted id ansit	Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events	malla	artery dis	Pase		Years
Ö,	e exe sian ar urial-t		resulting in death) Last Due to (or as a	consequence of	f):			/
68760,	tificate be executed g physician and as the burial-transit	edical	d					
Box	= 0,10		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pregnant				23d. Dat	te of delivery
	death ne atte	Physician/M	in the past 12 months?		3 □Ectopic pregnancy 5 □ Other (specify)			onth Day Year
О	at the	Phys	9 🗆 Onknown					
ďg.	The law requires that the death cer the has been signed by the attendin age 2 should be detached for use		Part Other significant/conditions contributing to death bu	I not resulting in	the underlying cause given in Part I.			ribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
ecords,	w requir been si should	letec	1- INDIGENSIUS			24a. Was		
Y	The lav	Completed by	1) /perconsis			auto	ppsy ormed?	Were autopsy findings available prior to completion of cause of death?
Vital	(0 11	Be C	25. Was case referred to medical		26. Place	of Death (Check only		I ☐ Yes 2 ☐ No
or <	Physic this ce al direc	To E	examiner? 1 Yes 2 No Hospital: 1 Inpatien	it 2 ER/Out	patient 3 DOA Other: 4 Nu	rsing Home 5 ☐ Res	idence 6 □Oth	er (Specify)
u C	ling After uner	ion:	27. Manner of Death 28a. Date of Injury Natural 5 ☐ Pending (Month, Day)		jury Work?		how injury occurr	red
DIVISION	I or Attendi after death. Director: A d in by the fu	fical	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injur	ry - At home, farr	M 1 ☐ Yes 2 ☐ i m, street, factory, office		Street and Number	er or Rural Route Number.
	늘하는	Certification:	4 Homicide determined building, etc.	(Specify)		City or To	wn, State)	
	To the Hospital of within 24 hours af To the Funeral D completely filled in		29a. Certif Cock only dedical Examiner: On the basis of	f my knowledge, examination and	death occurred at the time, date an	d place, and due to the	cause(s) and ma	unner as stated.
	o the ithin 2 o the	Medical	and manner state	ed.	29c. License number			d (Month, Day, Year)
)	⊢≯Fŏ		(//////////)	D-457K	7	01/09	1/2008
		-	30. Name and address of person who completed cause of de	ath (Item 23a) (T	ype, Print)	J	-/	1 7000
5	V I VA		DR. JOHN MULVEY 111	WEST	4164 STREET	SUTTE 309	ELKT	EN Md. 21921
	Star Registra	.6	31. Date filed (Month, Day, Year) 32. Registral JAN 1 1 2008	s Signature	Sale			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 20b per fh, 8876,02/16/08dhb Registrar Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 19,2008 Ethel Virginia January 10:40 PM /Medical Myers 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Homewood at Williamsport Williamsport Washington

9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🙀 F Months Days Hours Min. 97 Yrs. 219-20-1582 Director April 26,1910 Maryland Usual Residence of Decedent the Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov notified at Director 1 ☐Yes 2 No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or iner must be n 16505 Virginia Avenue 21795 U.S.A.

14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or item dical Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If tem 27 is marked other the any Injury or other traumatic event, the once. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Franklin Myers Bowman Bessie <u>May</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen D. Kiley Friend <u> 14 West Potomac Street, Williamsport, Md. 21795</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ↑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 01/24/2008 Hagerstown, Maryland Rest Haven Cemetery Andrew K. Coffman Funeral Home, Inc. 40 East Antietam St., Hagerstown, Md. 21. Signature of Funeral Service Licensee R. hoel Braa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, —thas cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RUNAN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to finite solute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequênce of). Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown er significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by NCCCH 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Medical Certification: To ō 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation death. 1 🗌 Yes 2 □ No Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral I 🕻 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b, Signat 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar

DHMH 17 Rev 1/2001

30. Name and address of p

31. Date filed (Month, Day,

Year)

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08-00608	
Paula McClain	

aula McClain		State 1- For State Registrar	of Maryland		artment of <i>tificate of</i>		Mental		eg. No. 2 (1	08 027
Physici Medical Exam		Decedent's Name (First, Middle,La	,					2. Date of Dea Month		3. Time of Death
viedicai Exam	ner	Paula J	o McClai	n	Tz	b. City, Town, or L	ocation of D	January 2	2, 2008 4c. County of Dea	0745 hrs
		Calvert Memorial Hospita				Prince Frede		Call	Calvert	01
Funeral		5. Social Security Number 6. S	Sex 7. Age	e (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 2	1.4 m	Fore	irthplace (State or
Director			M 2XF	4 5	Yrs		Hours	12/27	/1962 0	ountry) PA
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locati	on				10d. Inside City Limits
and show	٥	MD Calver	t			Chesape	ake Be	each		1 XYes 2 No
Mary r 28a-	irect	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What Co	untry?
5-0036 led within 72 hours after death with the Maryland Tygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Funeral Director	3512 Elizabeth 11. Marital Status	Court 12. Was Decedent	Ever in II	S 13 Wa	207		(Specify Yes or No	USA	rican Indian, Black,
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, after c ral", o	by F		d If Yes, Give Year			Yes 2X No			Specify: W	nite
5-0036 led within 72 hours afte dygiene. other than "natural", the Medical Examiner	fed	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5			t's Usual Occupations of working life.			16b. Kind of Business	/Industry
036 ithin 7: ne. r than ledical	Completed	12	conege (1 + or c	,.,	Schoo	l bus ai	de		Board of	Education
15-0C filed wit Hygien d other , the M		17. Father's Name (First, Middle, Las	t)					lame (First, Middle, I		
21215-1 uld be filed Mental Hyg marked oth	o Be	Robert John 19a. Informant's Name/Relationship (McClain Type, Print)		19b. Mailing	Address (Street		orie Ka	nber, City or Town, Star	e Zin Code\
MD 21215-0036 at 2 should be filed within 7 thin and Mental Hygiene. n 27 is marked other than numatic event, the Medica	-	Robert J. McCla		er					peake Beach	
Baltimore, MD 212 permit. Pages I and 2 should b Department of Health and Ment Important: If item 27 is marking or other traumatic even		20a. Method of Disposition 1 Burial 2 X Cremation 3				tion (Name of cerr		Date	20c. Location - City of	
Baltimore, permit. Pages I an Department of Hea Important: If iter		4 Donation 5 Other Specif	/:						Alexandri	
Bal permi Depar Impor		21. Signature of Funeral Service Lice	nsee						ineral Home	
Physician	_	23a. Part I. Enter the disease, or comfailure. List only one cause on e	plications that caused	the death	Do not enter the	20 ML. H	such as cardi	iac or respiratory arr	vings, MD 2 rest, shock, or heart	Approximate Interval
/Medical xaminer		Immediate Cause (Final disease a	Atherosclero			ular disea	se			Between Onset and Death
		or condition resulting in death)	Due to (or as a conse	quence o	f):					
	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Unuerlying Cause	Due to (or as a conse	quence o	f):					
=	xam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence o	f):					
60, ate be executed hysician and e burial - transit	al Ex	177								
60, ate be ez hysiciar e burial	Medical	X UNPENDED	#23a_PTT_2			2/4/08 TT			Tarrantin	
6876 ertifica fing ph	sician/N	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fe	al death 3	Ectopic pro	egnancy	23d. Date of delive Month	ry Day Year
Box 6876; death certificate the attending phy	ysici	1 Yes 2 No 9 V Unknow	Pregnant at	time of de	ath 5 Oth	ner (Specify)				
P.O. Best hat the degree by the detached f	/ Phy	Part II. Other significant conditions		but not re	esulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
S, P.C	ed by	Diabetes mellitus	s; obesity; C	hronic	obstruc	tive pulmor	ary	1 Ye	s 2 No 3 Pro	obably 4 V Unknown
of Vital Records, g Physician: The law requir ther this certificate has been s meral director, page 2 should t	Completed	disease (COPD)						24a. Was autop	osy prior to	autopsy findings available completion of cause of
Vital Rec ysician: The l his certificate b	5							1 Yes	rmed? death?	res 2 No
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of \ng Phy	n: To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Day,Yo		28b. Time of Ir				how injury occurred	
Sion attendi death. ctor: 2	atio	1 X Natural 5 Pending 2 Accident Investigation		,,		1 Y	es 2 No)		
Division pital or Attendir ours after death. ceral Director: A	Certification:	3 Suicide 6 Could not determine	be	ury - At ho	ome, farm, stree	t, factory, office bu	ilding, etc.	28f. Location (or Town, S		Rural Route Number, City
<u></u>		20a Certifier	(Opcomy)	knowleda	ge, death occur	red at the time, dat	e and place.	and due to the caus	se(s) and manner as sta	ated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examine								
	ž	29b. Signature and title of certifier				29c. License			29d. Date signed (M	
	ļ	30 Name and address of acres	completed rause of de	noth (12	2201	O.C.N	1.E.		January 23, 200	J8
		 Name and address of person who Ling Li, MD Assistant N 	completed cause of de Medical Examiner	,	,	t, Baltimore, N	1D 21201			
	ate	31. Date filed (Month ANY 2) 8	2008 32. Régistrar	's Signatu	re					
Regist	rair		J. M.	500	O. Am					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12 Per Physician Stanton 11.49 PM Ε. Morsell 2000 JAN /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | Nov. 1,1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** Months 1 M M 2 □ F 214-28-3942 81 Yrs. Director Usual Residence of Decedent with the Maryland 10b. County 10a State 10c. City, Town or Location "natural", or Items 23a or 28a-f ahow adical Examinar must be notified at 10d. Inside City Limits MD Baltimore 1 XYes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3727 Columbus Drive 21215 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Menial Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examinar must applicate. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard Ε. Morsell Mary Alice Sewell ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma Easton/sister 6010 Solomons Island Rd. Huntingtown, MD2063 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Plum Pt. UMC (20c. Location - City or Town, State UMC Cem. 1/19/2008 Huntingtown, MD 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road 21. Signature of Funeral Service Licensee Glady G Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine anding physicien and use as the burial-transit law requires thet the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical been signed by the attending should be detached for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 22 ER/Outpatient this 3□ DOA To the Hospitel or Attending Ph within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) allham 28595 Ashen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 AVE, SUITE 203 TASNEEM AKHANI 32. Registra Signature 31. Date filed (Month, Day, State Registrar

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Exa	mine	r	4a. Facility Name (If not institution, give stre FREDERICK MEMORIAL			4b. City, Town, or FREDER	Location of Death		4c. County of Death	
Fune	ral		5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birtl	nplace (State or Foreign
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and w		-	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	cation				10d. Inside City Limits
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permit. Pages 1 and 2 Department of Health a Important: If item 27 if			20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Rem			sition (Name of ngry or other place	ne) 1/15/		20c. Location - City or Emmitsburg	
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician Edna Mavis McAvov 2008 an /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salisburg RehabaNursing If Under 1 Year | If Under 24 H/s. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 🔀 579-20-7801 Director 11/22/1922 Missouri Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10h County 1x Yes 2□No Directo Salisbury Maryland Wicomico 10g. Citizen of What Country? 10e. Street and Number 21804 USA 200 Civic Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married M ΔViS M ΔVO Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white Specify. 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) agent real estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Turrel William Waggoner Bessie Means 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1205 Ocean Parkway, Berlin, MD 21811 Patricia A. Waggoner/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 1/16/08 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Margod Funcial Service Licensee Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ear erner disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 : performed? 2 - NO or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 | Yes 2 | No 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day 28h Time of 28d. Describe how injury occurred 27. Manner of Death After 5 ☐ Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

within 24 hours a To the Funeral C Medical completely To the I

State Registrar

2008

1

29b. Signature and title of certifier

llam

31. Date filed (Month, Day, Year)



and manner stated.

Robins, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Mary		artment of I rtificate of			giene 2	008 02741
	Physici /Medic		Decedent's Name (First, Middle, L. Norman Decedent's Norman Decedent D	ast) ale Macon	า			2. Date of De Month	ath Day	Year S: 25 A M
*	Examin Funeral Director		,	Sex 7. Age (Ir. 70	yrs. last birthday) Yrs.	Salsk If Under 1 Year Months Days	or Location of Dea	s. 8. Date of Bir	th ly, Year)	y of Death 9. Birthplace (State or Foreign Country) Texas 10d. Inside City Limits
Maryland 21215-0036	2 should be filed within 72 hours efter death with the Maryland nem Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show raumatle event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	Maryland Wicomi 10e. Street and Number 505 Washington 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest green and the status) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last Claude Macon	St. 12. Was Decedent Ever Armed Forces? 1 2 Yes 2 No If Yes, Give Year or Dates: Navidade completed) College (1-4or 5+)	vy 16a. Dece (Give life. elect	10f. Zip Code 21804 Was Decedent of I If Yes, specify Cub 1 Yes 2 No dent's Usual Occup kind of work done DO NOT use retire	dispanic Origin? (: an, Mexican, Pue Specify: Deation during most of wood) ntractor 18. Mother's Na Bert	orking ame (First, Middle, ie Powe	USA 14. Ra Bla Specia 16b. Kind of B elect Maiden Surnal 11	Business/Industry rical me)
Baltimore, Mar	permit. Pages 1 end 2 should Department of Health end Mer Important: If Item 27 Is marke any Injury or other traumatic once.		19a. Informant's Name/Relationship Valerie Dawson/ 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 ☐ 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Liveral Service	daughter Removal from State	709 Ob. Place of Disportentery, cre Salisbury	ng Address (Street S. Kaywo position (Name of matory or other pla Y Cremato Charles (Addre 501 Snow	ood Dr.,	Salisbur Date 17/08	20c. Location Salisb	
8760,	Physician bhysician and street pe executed the private in the purial-transit the purial-transit the private in	dical Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		nsequence of): OBSTP- nsequence of):	er the mode of dyi				Approximate Inferval Between Onset and Death
P.O. Box 6	the death certify the attending ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions	23c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3[e of death 5[Ectopic pregnanc Other (specify)		23e. Did t	М	ate of delivery onth Day Year
al Records,	The law requiate has been sage 2 should	Completed by						24a. Was autoperfo	Yes 2 No an 24b. psy rmed?	Were autopsy findings available prior to completion of cause of death?
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Divi	F ⊊ te		4 Homicide determined		pecify) y knowledge, deal	h occurred at the t	ime, date and plac	City or Tou	vn, State) cause(s) and m	ber or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29b. Signature and title of certifier	and manner stated.	anniauon anuon II	29c. Licens	se number		29d. Date signe	ed (Month, Day, Year)
	Sta Registr		30. Name and address of person who GHUAU WAR 9 31. Date filed (Month, Day, Year) JAN 182	completed cause of death COASTAL 32. Jegistrar's	Hospica	Print) Po 0	ok 173	3 SAL	is Bul	16/08 My mo 2/802

Norman D. Macon

		•	For State Registrar	State of Ma	aryland		artment of F rtificate of		•	giene Reg. No.	200	8 0274
	Dhuniai		1. Decedent's Name (First, Middle	e, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physici: /Medic	al	MARY LAURITA P				4h Oibi Taura	al costing of Dogth	1/11/	/2008	ounty of Dea	5:38 P ^M
	Examin	er	4a. Facility Name (If not institution 31905 GRIFFITH				GALI	or Location of Death			KENT	
	Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. las	t birthday)	If Under 1 Year Months Days		8. Date of Bir (Month, Da	th	9. Bir	thplace (State or Foreign
П	Director		530-16-6560	1 □ M 2 🛣 [30	Yrs.	Months Days	Hours Will.	02/13/			KS
	w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Lo	cation					10d. Inside City Limits
	Maryla f sho	ò	MD KE		GALE	ENA						1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Co	ountry?
	th witl 23a o 1st be		31905 GRIFFIT				2163				USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☒ Widowed 4 ☐ Divorced	If Von Civo	Ever in U.S. No	ł	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2X No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify: W	te, etc.
21215-0036	n 72 hou "natura edical E	Completed	(Specify only highe	it's Education est grade completed)	- 10	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of world	king	16b. Kind	d of Business	/Industry
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Maryland 2	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Lawrence Ross	Last)				18. Mother's Nam		, Maiden S	Gurname)	
	ind 2 should I alth and Men 27 is marke er traumatic		19a. Informant's Name/Relations Karen A. Duda					t and Number or Ru 'errace Ur				
altimore,	permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any Injury or other tra		20a. Method of Disposition Burial 2 Cremation Donation 5 Other (\$		cen	netery, cre	osition (Name of matory or other pla cans Ceme	tery 1/23	Date 3/2008		enham	Town, State , Maryland
Balti	permit. Departn Importa any Inju		21. Signature of Funeral Service	Birgual	#	D2 44	Name and Addr Dnald V. 100 Powde	Borgwardt r Mill Ro	Funera ad Belt	l Hon svill	ne, PA le, Mar	yland 20705
1	Physician		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition	r complications that caused only one cause on each line	the death.		ter the mode of dy		or respiratory a	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a conseque							
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<u>,</u>	iicate be executed physician and s the bunal-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	Due to (or as a consequence of):							
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Division or Vital Records, P.O. Box 6	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal d	leath 3	⊒Ectopic pregnand ☐ Other (specify)	су		23	3d. Date of de Month	elivery Day Year
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Recor	nysician: The law requir nis certificate has been si I director, page 2 should I	Completed	Diubata) 5					24a. Was auto perf 1 Yes	opsy ormed?/	prior to death?	autopsy findings available completion of cause of
ta	lan: "	Be C	25. Was case referred to medica examiner?	ıl				26. Place of Dea				
<u>~</u>	Physician: r this certifica ral director, p	To E	1 Yes 2 No		ent 2 El		III 3 DOA		ome 5X Res			ecify)
n C	ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pendi		y Year) 2	28b. Time o Injury	W	uryat ork?]Yes 2∐No	28d. Describe	how injury	occurred	
ivisio	or Attend fter death Director: , in by the f	Certification:	3 Suicide 6 Could	not be nined 28e. Place of inju- building, etc			reet, factory, office			(Street and own, State)	Number or F	Rural Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical Ce	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physiclan: To the best of the basis of and manner sta	f examination	ledge, dea on and/or ii	th occurred at the ovestigation, in my	time, date and place opinion, death occu	and due to the urred at the time	e cause(s) e, date and	and manner a place, and du	as stated. ue to the cause(s)
	o the ithin 2 o the omple	Med	29b. Signature and title of certifi	11/-1-1	with.		29c. Licer	nse number		29d. Date	signed (Mor	oth, Day, Year)
	⊢ 3 ⊢ ŏ /		Lew !	an			D	5882	4		1/14/	28
	6		30. Name end address of person Paul Anthony D	n who completed cause of donaher, M.D.	leath (Item 2	23a) (Type North	Print)		*	yland	21635	
	Sta Regist		31. Date filed (Month, Day, Year JAN 1	7 2008 32. Polistra	rar's Signatu	ire	Courte)					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) PUSEY 2100. PM CHARLES **Physician** 2008 01 /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Kennedy 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Washington DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 20 6216 Kennedy Funeral within 72 hours efter death 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Armed Forces: 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1965 - 69 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Black þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) is marked other than Elementary/Secondary (0-12) Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship Department of Health as Important: If item 27 is any injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 □Removal from State Cem. 1-24-08 Ar.
22. Name and Address of Facility Hunt Fune And, Net. 4 ☐ Donation 5 ☐ Other (Specify) Home 21. Signature of Funeral Service Li 908 Kennedy St. NW unl Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PANCREATIC CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burlal-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached fo Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was an autopsy performed?
Yes 2 XNo 1∐ Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 3 ☐ DOA 5 Residence 6 □Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To s after death.

I Director: After this of in by the funeral di 27. Manner of Death 1 X Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29b. Signature and title of certifier DEFENSE 1 46 HWAY ANNAPOLIS MOLHOL Name and address of person who complyind cause of death (Item 23a) (Type, Print) 021438 ENTA MO 31. Date filed (Month, Pay, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 17^{Day} Month **Physician** 2008 5:55 A M Florence Parsons /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5 Washington St. Berlin Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 8/31/1912 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 K F 214-34-5848 95 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2¥ No Director MD Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Washington St. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore. Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Completed by Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15, Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Algie Ellis Wimbrow Della Oliphant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Carter / daughter 31 Cedarhill Rd., Randallstown, MD 21133 Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State Evergreen Cemetery 1/21/2008 Berlin, MD 4 Donation 5 Other (Specify) 21. Signature of Funera 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death Po not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a co equence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregra 3 ☐ Ectopic pregnancy in the past 12 mor Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown nis certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No this certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Mesidence 6 □Other (Specify) ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) title of certifier 29c. License number 29b. Signatur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) gate 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 18 2008

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien [Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 01 8:30 P.M. 2008 Loretta Fav Robinson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NMS Healthcare of Hagerstown Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 74 11/23/1933 169-26-2052 Pennsylvania Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other then "naturel", or items 23a or 28a-f show other treumatic event, the Modical Experience ust be notified at 1 Yes XX No Mary land Washington Hagerstown Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14014 Marsh Pike 21742 USA death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after in nont of Health and Mental Hygiene. ant: If item 27 is marked other then "naturel", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 ☐ Widowed 4 1 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Store Clerk Retail Sales 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beatrice Schultz ٩ Arthur L. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2392 Cito Road, Big Cove Tannery, PA 17212 Kevin E. Robinson Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition ₩ Burial 2 □ Cremation 3 Removal from State permit. Pages
Department of
Important: If it
any injury or o 01/16/2008 Marburg Memorial Gardens Hanover, PA 22. Name and Address of Facility
Kenworthy Euneral Home, Inc., 269 Frederick Street
Hanover, PA 17331 21. Signature of Funeral Service Licenses CC 0354 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Cere Do ONO Sa **Physician** 10 resulting in death) /Medical Due to (or as a consequence of): Examiner rator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 s 1□ Yes 2 **N**0 To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 24 hours a 1 Secretifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 (5353 WJL 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muhammad Waseem, MD., 1126 Opal Court, Hagerstown, MD 21740 31. Date filed (Month, Day, Year) State JAN 16 Registrar 2008

DHMH 17 Rev 1/2001

State Registrar

	•	For State Registrar	State of Maryla	_	artment of F tificate of		ntal Hygien		02747	
° Physicia		1. Decedent's Name (First, Middle, Las.	,	G.	7	3		ay Year	3. Time of Death	
/Medic			Charlotte J	oan Sny				27, 2008	7:10 P M	
Examin	er	4a. Facility Name (If not institution, give Julia Manor Healt		r		or Location of Death erstown	4	c. County of Deat Washing		
*		5. Social Security Number 6. Se		s. last birthday)	If Under 1 Year		B. Date of Birth	g Birt	hplace (State or Foreign untry)	
Funeral Director			² M 2√2 F 7		Months Days	Hours Min.	(Month, Day, Year		^{untry)} lifornia	
		Usual Residence of Decedent								
Irylan show	_	10a. State 10b. County	10c.	City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
ih the Marylar or 28e-f show	ct	Maryland Washingt	on	На	gerstown		10-0	itizen of What Co		
th with the Maryla 23s or 28e-f shor	Dir	10e. Street and Number			10f. Zip Code	7.40	109. 0		antry r	
eath w	Funeral Director	640 Northern Ave.	12. Was Decedent Ever in	U.S. 13.1	217 Was Decedent of H		ify Yes or No-	U.S.A. 14. Race - Ame	rican Indian,	
ter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo			Hispanic Origin? (Spec lan, Mexican, Puerto R	ican, etc.)	Black, White	e, etc.	
0036 hours aff	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White	
d 21215-0036 Ilied within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28e-f show ont, the Madical Examinator unit by notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup	during most of working		Kind of Business/	Industry	
21215-0 s within 72 ho liene. In mad natu	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.						
nd 212 e filed withing the Will Hygiene.		10 17. Father's Name (First, Middle, Last)			Homemake	18. Mother's Name	First Middle Maide	Home		
Bala B	Be	William L. Tho	mas			Mary L.		,		
re, Maryland s 1 and 2 should be file Health and Mental Hy liem 27 is marked ofth other treumatic event	은	19a. Informant's Name/Relationship (7		19b. Mailie	ng Address (Street	and Number or Rural		or Town, State, 2	Zip Code)	
Ma od 2 s lih ar 27 is	l	David T. Snyder	(Son)	1381	1 Northci	rest Rd. Ha	gerstown,	, Marylan	nd 21742	
re, M s 1 and 2 f Health item 27 other tr		20a. Method of Disposition		. Place of Dispo	sition (Name of matory or other pla	Da	te 20c.	Location - City or		
Page lent o nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from State) Si	-	rg Cremat	Uallu	ary 2008 Smi	thsburg	, Maryland	
Baltimore, learning the permit. Pages 1 am Department of Heal Importent: If item 2 any lajury or other once.		21. Signature of Funeral Service Licen			2. Name and Addre		L. Davis	Funeral	Home	
a 50 5 5 8		23a. Fart1. Enter the disease, or comp	Davis Mole			bury Ave.		g, Mary	Approximate Interval Between	
Physician Medical Examiner Physician and Phy	Examiner	shock, or heart failure. List only of the shock of the sh	a. Due to (or as a cons	al al	dosti Steno	0	Arone		Onset and Death	
Box 687 death certificate a attending phys of for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 275No 9 □ Unknown	d	etal death 3	□Ectopic pregnanc □ Other (specify) _	÷y		23d. Date of de Month	livery Day Year	
P.O.	by Ph	Part II. Other significant conditions of	ontributing to death but not	ven in Part I.	23e. Did tobacco	o use contribute to	the cause of death?			
cords,			1 🗆 Yes	2 No 3 P	robably 4 Unknown					
of Vital Records, Physician: The law requires t this cartificate has been signe	Completed						24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of 2 No	
Vital Resident The certificate herector, page	Be	25. Was case referred to medical examiner?	Hospital:		01	26. Place of Death				
Of Physical direction	유	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Linpatient 2	ER/Outpatien 28b. Time o	IL 3 DOA	4 × Nursing Hom	e 5 Residence 8d. Describe how in		city)	
on of ding Ph h. After th funeral	tlon	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 1 Death 5 Pending (Month, Day Year) 27. Macrident investigation 28d. Date of Injury 48b. Time of Injury 48c. Injury at Work? 1 Yes 2 No								
Division To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route N City or Town, State)								
To the Hospit within 24 hours To the Funer completely fille	edical (29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the ti vestigation, in my	ime, date and place, a opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)	
To th withir To th comp	M	29b. Signature and title of certifier				se number	29d. [Date signed (Mont	th, Day, Year)	
			1		423	52323	0	1-20-	2008	
φ		30. Name and address of person who of Muhammad	completed cause of death (I	tem 23a) (Type,	print) medica	1 group	Hagers	town, r	-2008 ND.	
Sta	ite	31. Date filed (Manus, Bay Year) 20	08 32 Registrar's Si	gnature	Care of		U	,		

			For State Registrar	State of Man		artment of H			2008	02748	
	Physicia		1. Decedent's Name (First, Middle, Last)					Day Year	3. Time of Death		
	/Medic	al	Sara Jar			45 City Town or	Location of Death	January	27, 2008	5:55 PM M	
	Examin	er	4a. Facility Name (If not institution, give st Homewood at Crum1	and Farms		Frederi			Frederick		
	Funeral Director		DIT 31 OIIO		In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Aug. 14,	(ear) 9. Birthi Cour Mar	place (State or Foreign orty) yland	
Maryland e-f ehow	Maryland e-f ehow	ctor	Usual Residence of Decedent 10a. State Maryland Trederick		oc. City, Town or Lo Frederick					10d. Inside City Limits 1 Aves 2 No	
	th with the 23a or 28 ast be rip	Funeral Director	10e. Street and Number 104 Mercer Court,	Suite 12	-1 B	10f. Zip Code 2170	01		g. Citizen of What Cou	ntry?	
036	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel; or items 23e or 28e-f ehow important: if item 27 is marked other than "naturel; or items 23e or 28e-f ehow appring or other treumatic event, the Madical Examinar must be multised at once.	Ď	11. Marital Status 1: 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.	
21215-0036	within 72 ho lene. than "natur iha Madical.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired Homemaker	during most of world)	king	6b. Kind of Business/Ir		
land 2	uld be filed fental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Harry Milton I	'ree	, , , , , , , , , , , , , , , , , , , ,			ne (First, Middle, Ma Kline	aiden Sumame)		
Maryland	nd 2 shou alth and M 27 is mai		19a. Informant's Name/Relationship (Type Carol Ann Kepler,					ral Route Number, (atonsvill	City or Town, State, Ziple, MD 212		
Baltimore,	Pages 1 enent of Henant: If item		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Dispo cemetery, crea Rocky Spr	matory or other plac	ce)		Oc. Location · City or T B Frederic		
Balti	permit. Departn Importe any injt		21. Signature of Funeral Service License	neral Home ick, MD 217	701 Approximate						
	Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, a. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
P.O. Box 68760,	that the death certificate be executed ed by the ettending physicien and detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Due to (or as a concept of the conce	pregnancy □Fetal death 3[□Ectopic pregnancy □ Other (specify)			23d. Date of delin Month	very Day Year	
	sign d be		Part II. Other significant conditions conf	ributing to death but	not resulting in the u	inderlying cause giv	ren in Part I.		acco use contribute to	the cause of death? bably 4 \(\square\)Unknown	
I Reco	The law i ate hes by page 2 st	Completed by	0/3/1000	(051)				24a. Was an autopsy perform	24b. Were aut prior to c death? No 1 \(\subseteq Yes	opsy findings available ompletion of cause of	
Division of Vital Records,	nding Physician: Th ath. r: After this certificate e funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No H: 27. Manny of Death 1 Natural 5 Pending 2 Accident investigation	Ospitat: 1 ☐ Inpatient 28a. Date of Injury (Month, Day)		of 28c. Injur	ner: A Nursing H	ome 5 Resider 28d. Describe how	nce 6 Other (Spec	ify)	
Divis	ial or Attends after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,			
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Examin one)	icien: To the best of er: On the basis of ea and manner state	xamination and/or in	nvestigation, in my o	opinion, death occu	irred at the time, da	use(s) and manner as te and place, and due	to the cause(s)	
	To t To t	2	29b. Signature and title of pertifier	Kin	m)	29c. Licens D 164		29	d. Date signed (Month	Day, rear)	
	10		30. Name and address of person who con Casper E. Cline	III, M.D.	, 300 Wes	Print)	Street, I	rederick	, MD 21701	, 0	
	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 1 2008		's Signature						

J.O. D

D.O.D 1/27/08

Known to physicians as: Sava J. Stup

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB

Nama

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Myung Hee Nam, M.D., Frederick Memorial Hospital, 400 W 7th St., Frederick, MD21701

0003516

29d. Date signed (Month, Day, Year)

Jan 26,2008

Physicia /Medic Examin	æ
Funeral Director	
D	

For State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. important: If Item 27 is marked other than "naturai", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physicia /Medic Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a er death.

To the Funeral Lirector: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year AM														Death	
ician dical	-	James R	. Shill	inger							January	16			3:27	A^{M}	
niner		4a. Facility Name (If	4b. City,	Town, o	r Location of	f Death		4c.	c. County of Death								
elega.		Casey Ho			i If I In de		ockvi		0.0.1.65111		Mont						
al		5. Social Security N 177-38-25		3.Sex 7 1527M 2□F	. Age (<i>In yr</i> s 60	s. last birthda Yrs.	Months	r 1 Year Days	Hours	A dian	8. Date of Birth (Month, Day, Feb. 23	Year)	7	9. Birthpla Count	nce (State or ry) PA	Foreign	
or	-	Usual Residence of		A	- 00						100. 25	, 1) 7	/		IA		
	Ī	10a. State	10b. County		10c. C	ity, Town or	Location		_					10	d. Inside City	/ Limits	
1		MD	Montg	omery				Darn	estow	n					1 🗌 Yes	2 XNo	
		10e. Street and Nur		D 1			10f. Zip	Code	,	2007		-	zen of Wh		-		
200	8	12604 Tr	ipie Cr			110	D 14/ D	1 -1 -11		2087			nite				
١	5	 Marital Status Mever Marri 	ind 2 WMarrin	12. Was Deced Armed Ford 1 ☐ Yes 2	es?	U.S. 1	If Yes, spe	dent of H	an, Mexican	in? (Spe , Puerto	ecify Yes or No- Rican, etc.)		14. Race - Black,	White, e			
2	2	3 ☐ Widowed		If Yes, Give Year or Dat			1 🗆 Yes	2 🕅 No	Specify:				Specify:	Wh	ite		
Completed by Funeral Director	3	(Snee	15. Decedent's	Education grade completed)		16a. De	cedent's Usu ve kind of wo	al Occup	ation	of worki	00	16b. Ki	nd of Busi	iness/Ind	ustry		
100	2	Elementary/Seco		College (1-4	or 5+)	life	e. DO NOT u	se retire	d) -		ng	Dep	artm	ent	of lab	or	
ج	3	47 Fatharia Nama /	(Final Middle 1			CI.	iminal	TIIV			/First Middle 1	Anidan	Curan				
8	3	17. Father's Name (ssi) Shillinge:	_						<i>(First, Middle, I</i> es Jane)			
P	-				-	19h Ma	ilina Address	s (Street						tate Zin	Code)		
		19a. Informant's Name/Relationship (Type. Print) Sheila A. Shillinger /Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12604 Triple Crown Road, Darnestown, MD 20878															
V.	1	20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - Consistent Consi											cation - C	ity or Tov	vn, State		
4		1 Burial 2 Micremation 3 Removal from State determined by the Crematory of other place) 4 Donation 5 Other (Specify) Alexandr											ria.	Virgi	nia		
ouce.	Ī	21. Signature of Fu	ineral Service Li	censee			22. Name a	nd Addre			10 Fa						
a		IRAC	/ /								, 10 Eas sburg, N		0877	Park	Drive	,	
		snock, or nea	rt tailure. List o	omplications that car nly one cause on eac	used the dea ch line.	ath. Do not e	enter the mod	de of dyir	ng, such as	cardiac c	or respiratory arre	est,			Approximate Interval Betw Onset and D	een .	
n -	1	disease or condition resulting in death) Breast Cancer															
ai er		Due to (or as a consequence of):															
i d	5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying. Due to (or as a consequence of):															
j.	1	cause. Enter Underlying Cause. (Ubsease or influry that initiated events c.															
H.	resulting in death) Last Due to (or as a consequence of):																
ian/Medical Examiner	3	d															
Me		IF FEMALE: 23b. Was decoded program 23c. If yes, outcome pf pregnancy															
0.3		in the past 12 months? 1 Dive birth 2 Fetal death 3 Ectopic pregnancy										2	23d. Date of delivery Month Day			ear	
Physic	2	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown											4				
2														o use contribute to the cause of death?			
Completed by	3	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unkn													nknown		
plet	2	24a. Was an 2											24b. W	24b. Were autopsy findings available			
, E		autopsy performed? 1□ Yes 2 汉 1															
Be		25. Was case reference examiner?	red to medical					1		of Death	(Check only on	e)					
٤	2	1 Yes 2				ER/Outpat			4 LI Nur		me 5 Reside				Hosp:	ice	
ion		27. Manner of Death 1 Natural	5 ☐ Pending investiga		Day Year)	28b. Time Injur	y M	28c. Injur Wor	yat k? Yes 2∐N		28d. Describe ho	ow injur	y occurred	a			
ij.	3	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could no determin	t be 28e. Place o	f injury - At I	home, farm,					28f. Location (St	reet an	d Number	r or Rural	Route Numb	per,	
Certification:		4 Homicide	determin	building	g, etc. (Spec	cify)					City or Tòwi	n, State,)				
Medical		29a. Certifier (Check polyone) / 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
Me													(Month, £	ay, Year)			
		Brenere Wolled & und D0064615 January 16, 200													, 2008		
	1	30. N 60 and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblewski, M.D., 1355 Piccard Drive, Suite 100, Rockville, MD 20850															
		Genevieve 31. Date filed (Mont			o., 13 distrar's Sigr		card_	Driv	e, Sui	ite :	100, Roc	kvi	11e,	MD 2	20850		
State strar		OT. Date filed (MOIII	JAN I'7	2008	Side a	K.	South										
					-	-	Pro St.										

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of N	/larylan	id / Depa <i>Cei</i>	artment d <i>tificate</i>	of Hea of De	alth and eath	Mental	Hygiei Reg.		0 7	2751	
H	Physici /Medic		Decedent's Name (First, Middle, Claren	ce Benson	Smith	, Sr.				2. Date of Month	1	eath 3. Time of 2			
Ā	Examin			4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death								4c. County of D	eath	:45 p ^M	
**	<u> </u>		Laurelwood 5. Social Security Number 6			last birthday)	If Under 1		ton Under 24 H	rs 9 Date	l Rieth		Cec.	il State or Foreign	
	Funeral Director		219-42-5689	1⊠M 2□F	61	Yrs.			Hours Mi	Jan.	Birth h, Day, Ye 17,]	ar) 1946	Country)	yland	
	p.		Usual Residence of Decedent		140 00										
	death with the Maryland rms 23a or 28a-f show protections	j.	10a. State 10b. County 10c. City, Town or Location Maryland Cecil Perryville											side City Limits ☐ Yes 2 ☑ No	
the M 28a-f	Director	10e. Street and Number	1		10f. Zip Co		тте		100.	Citizen of What					
	h with 23a or	ai Di	405 Reservoir R	oad				2190	3			υ.	S.A.	3.A.	
	ams ams	Funeral	11. Marital Status	11. Marital Status 12. Was Decedent Armed Forces?			Vas Deceden I Yes, specify	t of Hispa Cuban, N	anic Origin? Mexican, Pu	(Specify Yes of	or No-	14. Race - A Black, W		dian,	
20	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, 2 ☒ № 11 ☐ Yes, Give Year or Dates:				I□Yes 2⊠		Specify:			Specify:	White	3	
2-003p	2 hours		15. Decedent's	15. Decedent's Education				ccupation	n		16b	16b. Kind of Business/Industry			
א ב	thin 7.	ompleted	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4o	r 5+)	(Give	kind of work of OO NOT use i	lone durii	ng most of w	vorking	orking				
V	led wi	O										iter			
yland	d be fi	Be c	17. Father's Name (First, Middle, Last) William Ardie Smith 18. Mother's Name (First, Middle, Maiden Sumame) Irene A. Kenney												
2	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene in firm 21 is marked other than "natural", or itams 23a or 28a-f show other treumatic svent, the Madical Examinar must be notified at	2	19a. Informant's Name/Relationship			19b. Mailin	g Address (S	treet and	Number or i			ty or Town, Stat	a, Zip Code	a)	
, Ma	and 2 laith a la 27 is er trei		Raymond E. Smit	h (Brother	<u>-</u>)	405 R	eservo	ir R	oad, I	Perryvi	lle,	Marylar	nd 219	903	
ore	or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	☐Removal from Stat	1 ~	Place of Dispo emetery, cren	sition (Name natory or othe	of r place)		Date		. Location - City	or Town, S	late	
pairimoi	t. Pag rtment rtent:		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Like	city)	R.	A. Ferri				1/17/08	_	st Cheste			
<u>a</u>	permit. Pages 'Department of H Important: If its sny injury or of once.		Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766											<i>A</i> .	
			23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final												
10	Physician /Medical		disease or condition resulting in death)	a NH		7+216	Col	00	CAN	ucer					
	Examiner		Due to (or as a consequence of):												
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00	tificate ig phy as the	a		0.											
Š	th cert tendin or use	an/N	IF FEMALE: 23b. Was decedent pregnant	Ectopic pregr	ancy			23d. Date of delivery			W				
	w requires that the death certific been signed by the ettending p should be detached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live birth 4□Pregnant 9□Unknown			Other (special				_	Month	Day	Year	
ŗ	that the the the the the the the the the th		Part II. Other significant conditions	contributing to death	but not res	ulting in the ur	derlying caus	e given ir	n Part I.	23e.	Did tobacc	o use contribute	o lo the cau	ise of death?	
cords,	quires on sign uld be	ed by									1 Ves	2 □No 3 □	Probably	4 □Unknown	
) ၁	law re as bec 2 sho	Completed								24a.	Was an autopsy	24b. Were	aulopsy fir	ndings available on of cause of	
<u> </u>	The cete h	Com								1 🗆 Y	performed	? death	?	-	
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	iclan certific	Be	25. Was case referred to medical examiner?	Hospital:				Other:	6. Place of D	eath (Check o	nly one)				
5	y Phys ar this eral di	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of In	iury	ER/Outpatien 28b. Time of		Injury at Work?				e 6 □Other (S njury occurred	pecify)		
NISIOII	ath. or: Ate	atio	Natural 5 Pending 2 Accident investical		Jay Year)	Injury	М		2 □ No						
<u> </u>	or Atte	Certification:	3 Suicide 6 Could not 4 Homicide determine	ad 188. Flace of I	njury - Al ho atc. <i>(Specif</i>)	ome, farm, stre y)	et, lactory, of	fice			on (Street r Town, St	t and Number or tate)	Rural Rou	te Number,	
_	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours either death, and the form of the theoretal Director Alter this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use and the funeral director.	edical Ce	(Check only 2 Madical Ex	Physician: To the bes	at of my kno of examina	wledge, death	occurred at t	he time, o	date and pla	ice, and due to	the cause	a(s) and manner	as stated.	cause(s)	
	o the ithin 2 o ths o	Med	one) 29b. Signature and title of dentities	and manner s	stated.			cense nu				Date signed (Mo			
	β≟≮⊣		•				0	540	73		TITA	NOB	-,,	•	
			30. Name and address of person	o completed cause of	death (Item	1 23a) (Type,	Print)		. ,	Mr.	1.24	^	107		
	0	-	31. Date filed (Month, Day, Year)		81	7 CI-	NRLHA	ANS	UTN	New	4571	×) €	17/	W	
	Sta Registr		JAN 2 2	2008 32. Hagis	JAKA .	ture.	and s								

DHMH 17 Rev 1/2001

			1 = For State Registrar	State of	Marylan		artmer <i>rtificat</i>			nd Me		iene)	008	02752	2
	Physic	an	Decedent's Name (First, Middle, Last) Decedent's Name (First, Middle, Last)										Year	3. Time of Death	_
	/Medi		Erich H. Selhor						anuary		2008	10:30 P	и		
	Examir	ner	4a. Facility Name (If not institution, g Sunbridge Nursiv		El	kton	Location of				county of Dea	ath			
	Funeral Director		180-34-4373	Sex 7. 12 M 2□ F	Age (In yrs.	last birthday) Yrs.	Months	Days	If Under 2 Hours	Min. 8	Date of Birth (Month, Day ecembe)	Year)	1921 Bi	rthplace (State or Foreig lountry) Germany	חנ
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	s
	Many F-f sh	ţ	Maryland Cec	il	Ear	rlevill	2e							1 ☐ Yes 2 ☐ X No	0
	r 28s	irec	10e. Street and Number	311			10f. Zip	Code			1	0g. Citize	on of What C	ountry?	
	th wit	aiD	99 Farmdale Road	!			2	1919				USA			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f show many nighty or other traumatic event; it a Mudical Examinar must be notified at DDGs.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	ss? ⊠No		Was Dece f Yes, spe 1 Yes		spanic Origi n, Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No- can, etc.)		Black, Whi	erican Indian, ite, etc. hite	
5-(72 h	etec	15. Decedent's (Specify only highest of			16a. Deced	ient's Usu kind of wo	al Occupa	tion uring most	of working	ġ.	16b. Kind	of Business	/Industry	
121	within noe. then	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Auto				,		A	1 4		
	filed with Hygiene. ther the	e Co	17. Father's Name (First, Middle, La.	st)		Auro	Meen	unce	18 Mother	's Name /	First, Middle, I	Aua			
Maryland	Mental Merked o	m	Oskar Friedrich	*					Amali			иашеп 3	umame)		
<u> </u>	2 should and Men is marke sumatic	2	19a. Informant's Name/Relationship			19b. Mailin	ng Address	(Street a			Route Number	City or	Town State	Zin Code)	
$\mathbf{\Sigma}$	nd 2 g		Erich R. Selhors			99 Fa					eville,				
re,	s 1 and f Health item 27 other tr		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nai	ne of	. 1	Dat	0	20c. Loca	-	Town, State	
3altimore	Pages nent of l		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from Sta	R.T.	emetery, cren Foard	Fune	nther place Lal.	Home.	P.A	23-08	Ris	ina Si	ın, Marylanı	d
alti.	permit. Page Department Important: if any injury or once.		21. Signature of Funeral Service Lic											crey morey-court	o.
Ö	Depa Impo any) n		R. T. Foard Funeral Home, P.A. 111 S. Queen Street, Rising Sun, Maryland 21911										
B			Approximate the disease, or complications mat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximately account to the disease, or complications mat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.											Approximate	4_
	Physician /Medical Examiner		Immediate Cause (Final	,										Interval Between Onset and Death	
711			disease or condition resulting in death)	a. Due to (or	as a consequ	CALL uence of):	CENSI	117						YEAR	
4			Sequentially list conditions b. HIS PRSSTATIZ CAMENOTA										YEONA		
1,1		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	Due tof(or as a consequence of):									7000	
	cuted nd ransi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Com	a CARONIC Boshelin ARHAY Disean									year	
0	e be executed rsician and e burial-transit	EX	resulting in death) Last	Due to (or	as a consequ										
8760,	cate be executed physician and the burial-transit	dicai		d											
		0 1	IF FEMALE:												
Вох	death certifi e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1☐Live birth	2 Fetal	ldeath 3□	Ectopic pr					23	d. Date of de Month	livery Day Year	
0	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5	Other (sp	ecify)					N. G. I.	Day Tour	
٥.	that the ed by detac		Part II. Other significant conditions	contributing to death	hut not resu	ulting in the us	derlying c	auco awa	n in Part I		23a Did tob	2000 1100	contribute t	o the cause of death?	
of Vital Records,	8 6 8	d by				stang at the ut	idonying o	auso givoi	THIT CALL		1 Xe			to the cause of death? Probably 4 □Unknown	
00	w requir	Completed									24a. Was ar	1	24h Were a	utopsy findings available	
Re	The lay	mo			77						autops: perforn	y ned?	prior to death?	completion of cause of	
tal		0	25. Was case referred to medical		_				26 Place o	f Dooth /	1 Yes 2	No	1 L Yes	2 □ No	
\geq	S S D	OB	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	atient 2 🗆	ER/Outpatient	3 □ DC	A Other			5 Reside		TOther (Soc	scifu)	
0		n: T	27. Manner of Death	28a. Date of Ir		28b. Time of	-	8c. Injury Work			d. Describe ho			icity)	
Ö	Attending In death.	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	on	Jay rear)	Injury	М		es 2⊡No	5					
Division	al or Attend after death i Director: , d in by the f	ertification;	3 Suicide 6 Could not 4 Homicide determine	289. Place of	Injury - At ho etc. (Specify	me, farm, stre	et, factory	, office		28f	Location (Sti	eet and	Number or R	ural Route Number,	
	Hospitel or 14 hours afte Funerel Dire tely filled in t	O													
	To the Hospitel or At within 24 hours after or To the Funerei Directompletely filled in by	ledicai	one)	hysician: To the be miner: On the basis and manner	or examinat	wledge, death tion and/or inv	occurred estigation,	at the time in my opi	e, date and nion, death	place, and occurred	I due to the ca at the time, da	use(s) ar ite and p	nd manner a lace, and du	s stated. e to the cause(s)	
	To To	Σ	29b. Signature and title of certifier	a M			290	License		123	29	4		th, Day, Year)	_
•			> P.N. News					000 697 33					21/09	ł.	
	(30. Name and address of person who	completed cause o	f death (Item	23a) (Type, 1	Print)	ו המ	10 -21	1921					
9	Ø Sta	te.		32. Regis	strar's Signat	lurg _a	10		ات رو،	(- '					
	Registra	4.0	31. Date filed (Month, Day, Year) JAN 22	2008	ELASO I	ura A	2842	×							

		,	For State Registrar	State o	f Marylan		artmer rtifica			and M	lental Hy	giene Reg. No	2000	02	753
F	Discount of		1. Decedent's Name (First, Middle, L	ast)							2. Date of De	eath Da	y Year	3. Time of	f Death
	Physici /Medic		Christine Lyn	ne Sulli	van							/200		3:40) P M
	Examin		4a. Facility Name (If not institution, gi	ve street and nui	mber)		4b. City	Town, or	Location of	of Death			. Counfy of Death		
	i jir. Lengar pagangangan	.5' -	5704 30th Ave						sville				rince Ge		
	Funeral			Sex 1 □ M 2 🖾 F	7. Age (In yrs.	last birthday) O Yrs.	Months		If Under Hours	Min.	8. Date of Bi (Month, D	rth ay, Year)		place (State ontry)	-
ij.	Director		Usual Residence of Decedent					L			2/14/1	957	Wash	ington	, D.C
	land ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside C	ity Limits
	Mary f sho	ō	MD Prince (leorge ! e	нуга	ttsvi1	10							1 🔀 Yes	2 🗆 No
	the 28a-	Director	10e. Street and Number	eorge a	пуа	CCSVII		p Code				10g. Cit	tizen of What Cou	ntry?	
	3a or		5704 30th Avenu	10				20	782				U.S.A		
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Dece	edent Ever in U	.S. 13.	Was Dece			gin? (Spe	ecify Yes or N Rican, etc.)	0-	14. Race - Ameri	can Indian,	
20	or Ite		1 ☑ Never Married 2 ☐ Married	Armed Fo	21 No						Hican, etc.)		Black, White,	etc.	
<u> </u>	ral", c	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	ates:		1 ☐ Yes	AZI NO	Specify:				Specify: Whi	.te	
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7	ithin ne. s Me	du.	Elementary/Secondary (0-12)	College (I-4or 5+)		DO NOT L		1)				ers for		_
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ב	be fill d otl	å	17. Father's Name (First, Middle, Las	:t)							(First, Middle		n Surname)		
Ž	nould be f Mental I narked of natic eve	٩	Alex Sullivan	· · ·		1 401 14 11		(2)			Langfor			<u> </u>	
Maryland 21	12 sh hand 7 Is n traun		19a. Informant's Name/Relationship	, ,,			_						or Town, State, Zi _l	o Coae)	
a)	es 1 and 2 should be of Health and Mental f item 27 Is marked o r other traumatic eve		Paula J. Perry, S	ister	20h F						zille,		cation - City or T	own State	
Baitimore,	Pages nent of I int: If its iry or o		1⊠ Burial 2 ☐ Cremation 3		State	Place of Dispo cemetery, cre									
			4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	-	Ft	. Linc			ery ; [ss of Facilit		2008		ntwood,		A .
g	permit. Departr Importa any Inji	, ,	21. Signature of Funeral Service Lich	Hand Hand	1	5 100					e, P.A.		:739 Balt Iyattsvil		
	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List onlimmediate Cause (Final disease or condition resulting in death)	y one cause on e	aused the deat each line. heimer (or as a conseq	s Dise		de of dyin	ig, such as	cardiac (or respiratory	arrest,		Approxima Interval Be Onset and	tween
8/60,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	n's Syn or as a conse (or as a consec	uence of:									
O. BOX 6	ires that the death certific signed by the attending p I be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2♥ No 9 □ Unknown	1 ☐ Live I	tcome pf pregnorth 2□Feta nant at time of co	al death 3	⊒Ectopic p ⊒Other (s		′				23d. Date of deliv Month	•	Year
J.	that ned b		Part II. Other significant conditions	contributing to d	eath but not res	sulting in the u	ınderlying	cause give	en in Part I		23e. Did	tobacco	use contribute to	the cause of	death?
<u> </u>	quires n sign	d by	Seizure Disorder	, Anxie	ty Diso	rder,	Depr	essio	n		1	Yes 2	No 3□ Pro	bably 4 🗆	Unknown
ဝ္ပ	w require been sign	Completed									24a. Wa	s an	24b. Were aut	opsy findings	available
Ψ Y	The la ite has	щ									auto per	opsy formed?	prior to co	impletion of o	cause of
Vital Records,			25. Was case referred to medical						26 Place	of Dooti	1 Yes ∩ (Check only	2 🖾 N	o 1 ☐ Yes	2 □ No	
		o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	1 FB/Outnatie	nt 3□ D	OA Oth	er.				6 □Other (Spec	(6.1)	
o	g Physer this eral dii	: To	27. Manner of Death	28a. Date	of Injury	28b. Time o		28c. Injur Worl			28d. Describe			'iy)	
0	th. :: Afte	tio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		th, Day Year)	Injury	М		k? Yes 2∐	No					
DIVISION	al or Attending Phy s after death. It Director: After this ed in by the funeral of	Certification:	3 Suicide 6 Could not 4 Homicide determine	4 Zee. Place	of injury - At hing, etc. (Speci		reet, facto	ry, office			28f. Location City or To		nd Number or Rui e)	al Route Nur	nber,
A	To the Hospital o within 24 hours aft To the Funeral D completely filled in	Medicai (miner: On the b									s) and manner as nd place, and due		s)
~	To the transfer of the transfe	ž	29b. Signature and title or certifier	٨			29	c. Licens	e number			29d. Da	ate signed (Month	, Day, Year)	
)				J m. 15	· _			D555	59			Jan	uary 14,	2008	
	2		30. Name and address of person wh	o completed caus	se of death (Iter	m 23a) (Type,	Print)								
	0	i (Thomas Edward Ma					ente	r Dri	ve#	316,	Green	nbelt, M	2077	0
	Sta		31. Date filed (Month, Day, Year)	32. F	Registrar's Signa	ature									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 09:00 AM Audrey Sutherland January 14,200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2879 Biggs Highway North East Ceci1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days 1 □ M 2 🕅 F Director 218-20-1893 89 May 8, 1918 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Maryland Cecil North East 1 ☐ Yes 21 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2879 Biggs Highway 21901 by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√XNo Specify: White 3√Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Keen Lily Preston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Noll / Niece 2879 Biggs Highway, North East, Maryland 21901 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harford Memorial 20a. Method of Disposition 20c. Location - City or Town, State January 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 19, 2008 Aberdeen, Maryland 21. Sign were First rai S 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestiv disease or condition resulting in death) lars /Medical Due to (or as consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 X No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2**A** No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 sl 24a. Was an was autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) elative Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number 29d, Date signed (Month, Dav. Year) s of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

Year) 2008

		1	For State Registrar	State of Mar		artment of H			iene g. No 20	08	02755
			Decedent's Name (First, Middle, Later)	st)				2. Date of Death	h Day	Year	3. Time of Death
	Physicia		Frank Leroy Sava	ıge				January	13, 20	08	10:28 PM
	/Medica		4a. Facility Name (If not institution, giv			4b. City, Town, or	r Location of Deatl	h	4c. County		
			1433 West Philad			North E		8. Date of Birth	Cec		Nace (State or Foreign
	Funeral	1	5. Social Security Number 6. S	INDM 2□E	'In yrs. last birthday) Yrs.	Months Days	Hours Min.	(Month, Day,		Cour	ntry)
	Director	-	219-60-7946 Usual Residence of Decedent		53			Nov. 9,	1954		land
	and it	-	10a. State 10b. County	1	Ioc. City, Town or Lo	ocation				1	Od. Inside City Limits
	Mary f sho	호	Maryland Cecil		North H	East					1 ☐ Yes 2 XNo
	r 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of		
	th wit	<u>a</u>	1433 West Philade			2190			United		es Indian,
	ems er mu	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		ck, White,	
3	or it	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Vivorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	'	1 ☐ Yes 2 🔀 No	Specify:		Specil	y: Whi	lte
5	hour tural' al Ex		15. Decedent's E		16a. Dece	dent's Usual Occup	pation		16b. Kind of B	lusiness/In	dustry
2	in 72 n "na n "na nedic	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+	(Give	kind of work done DO NOT use retire	d) auring most of wo	rkiriy			
7	y with	mo;	10			etary Dep			U.S. G		ment
2	be filed within 72 hours after death with the Marylan Hydjene. Hydjene, Hydjene, et al. Hydjene, et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Las	t)				me (First, Middle,	Maiden Surna	me)	
<u>a</u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene and a marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	2	Frank P. Savage			(0)		a Elburn Bural Route Numbe	r City or Town	State Zi	n Code)
0	2 sho		19a. Informant's Name/Relationship Valerie McMuller					Colora,			21917
2	it of Health and 2 should nt of Health and Men if item 27 is marke or other traumatic		20a. Method of Disposition	1 / Dister	20h Place of Disp	osition (Name of	1	Date	20c. Location		
5	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to		1 YBunal 2 □ Cremation 3 [Removal from State	North Eas	ematory or other pla	1	2008	North	East	, Maryland
	permit. Pages Department of Important: if it any Injury or o		4 ☐ Donation 5 ☐ Other (Spec			22. Name and Addre		Crouch Fu			, mary rang
סס	permit. Departr Importa any Inj		1/1/1/1	1/m	1:	27 South	Main Str	eet, Nort	th East	, Mar	ry1and 21901
			23a. Part1. Enter the disease, or cor shock, or heart failure. List onl	mplications that caused to	the death. Do not er	nter the mode of dy	ing, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
Н	Physician		Immediate Cause (Final disease or condition	Mata	at Ten	Prost	te Can	car			unknaun
).	/Medical		resulting in death)	Due to (or as a	consequence of):	1 0000		200			
	Examiner		Sequentially list conditions	b							
Н	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):						
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):						
ζ Q		calE									
20	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the			d							
POX	nding use a	M/n	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth		: Ectopic pregnan	cv			ate of deli Nonth	very Day Year
ň	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		Other (specify)			i '	VIOTILIT	Day
r Ö	at the by th tache	Physician/Med	9 Unknown		t and annuiting in the	underlying cause o	iven in Part I	23e. Did to	obacco use co	ntribute to	the cause of death?
	w requires that s been signed t should be deta	by	Part II. Other significant conditions	s contributing to death bu	it not resulting in the	underlying cause g	iveiriir aiti.	10		_	obably 4 Unknown
Hecords ,	requir een s ould							24a. Was	an 241	h Were au	itonsy findings available
ခ်	e law	Completed						 autoj perfo 	rmed?	death?	topsy findings available completion of cause of
	rsician: The law s certificate has b lirector, page 2 s						26 Place of D	1 Yes Death (Check only o	2 ANO	1 Ll Yes	2 No
Vital	siclar certif recto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 ER/Outpati	ent 3 DOA O	41	Home 5 Resi		Other (Spe	cify)
o	Phys er this eral dii	. To	27. Manner of Death	28a. Date of Inju (Month, Day	ry 28b. Time	of 28c. In	jury at	28d. Describe	how injury occ	urred	
Ö	nding tth. r: Afte e fune	ation	1 Natural 5 Pending 2 Accident investigat	ion	(rear)		☐Yes 2☐No				
Division or	Afte or dea recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ury - At home, farm, c. (Specify)	street, factory, offic	e	28f. Location (City or To	Street and Nu. wn, State)	mber or R	ural Route Number,
Ō	ital or rs aft rai Di			Physician: To the best	-f l sudadas da	ath conurred at the	time date and n	ace, and due to the	cause(s) and	manner a	s stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	29a. Certifier 1 CertifyIng (Check only one) 2 Medical Ex	raminer: On the basis o and manner st	f examination and/or	investigation, in m	y opinion, death o	ccurred at the time	, date and place	ce, and du	e to the cause(s)
	thin 2 the orthe	Med	29b. Signature and title of gertifier	// / /		29c. Lice	nse number		29d. Date sig	ned (Mon	th, Day, Year)
	F 3 F 8		Y // &	What		, Don	35653		01/15	200	४
7	П		30. Name and address of person w	ho completed cause of d	eath (Item 23a) (Typ	e, Print) St	ite 104				
	1		Dr. Martha A. Ho	sFord-Skapo	f, M.D.,1	11 High S	Street, E	Elkton, M	aryland	1 21	921
		tate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	مرياني					
	Regist	trar	011114 2 0 1111	The state of the s							

DHMH 17 Rev 1/2001

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			For State Registrar	State of M	aryland		artment of H		ind Me		iene	008	02756
A	Physici	an	1. Decedent's Name (First, Middle, La.		EPL	1 45				2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic	al	Margaret			7 6 8				January	T	2008	7:00 A M
	Examin	er	4a. Facility Name (If not institution, giv				4b. City, Town, o		f Death			unty of Death ine Aru	ndol
	Funeral	***	Anne Arundel Med. 5. Social Security Number 6. S		e (In yrs. las	it birthday)	Annapo If Under 1 Year	If Under 2	4 Hrs.	8. Date of Birth (Month, Day,			place (State or Foreign
350	Director			□M 2 X F	84	Yrs.	Months Days	Hours	Min.	(Month, Day, 11–27–1	923	Illi	nois
	pu ,		Usual Residence of Decedent		10- 07- 7	T							
	show	2	10a. State 10b. County		10c. City,	own or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Director	MD Anne Ar	undel			Lothiar	1		1	On Citizon	of What Cou	
	with a or	۵	5808 Greenock Re	Dec			207	711		'	US US		inty :
	ne 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13.1	Was Decedent of H		in? (Spec	offy Yes or No-		Race - Ameri	can Indian,
9	or Item	교	1 Never Married 2 Married	Armed Forces: 1 ☐ Yes 2 🔀					, Puerto F	Rican, etc.)		Black, White,	etc.
93	iral', c	d by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🂢 No	Specify:			Sp	ecify: wh:	ite
215-0036	illed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Iteme 23a or 28a-f show thit, the Medical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)		16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most	of workin	g	16b. Kind	of Business/In	dustry
121	withir ane. than	d E	Elementary/Secondary (0-12)	College (1-4or 5+	5+)	teac		1)			nuhl	ic sch	2001
d 21	Hygie Hygie ther	မ င်	17. Father's Name (First, Middle, Last,			Leac	ner	18. Mother	r's Name	(First, Middle, I			1001
an	ld be ental ked c	To B	Malcolm Alan	Poole				Luc	y C	ampbell	Cor	nway	
Maryland	2 should be filed within "n and Mental Hygiene." I e marked other than "raumatic event, Ita Med		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street	and Numbe	r or Rural	Route Number	, City or To	own, State, Zip	Code)
	5 = 2 t		David S. Shepher	d, son			Alwoodle	ey, W	illi	amsburg	, V	2318	88
Baltimore,	ges 1 ar t of Hea if Item or other		20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation 3 ☐	Removal from State	com	ce of Disponence of the contract of the contra	sition (Name of natory or other plac	(8)	Da	ate	20c. Locat	ion - City or To	own, State
Ë	. Pag tment tant: jury o		4 □ Donation 15 □ Other (Specific	y)			itan Cren					ndria,	
Bai	permit. Pages. Department of Inportant: If Ite any Injury or of		21. Signature of Funeral Service Licer	See			2. Name and Addres						
L.	10280		23a. Part1. Enter the disease, or com	nlications that cause	d the death		325 Mt. F					MD 207	Approximate
0			shock, or heart failure. List only Immediate Cause (Final	one cause on each I	ine.		·	-					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. VQ (مامد	20000000	Colla	nse	, m				hours
- %	Examiner			Sleed	Lina	90	colla oto int	ろんぶ	20	- CH	F		Lows
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consegrer	104 47.							
	nd nd transl	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· Ahr	al	1.5	rillahi	1-C	ar .	dion	Ma	15	years.
8760,	or Attending Physician: The law requires that the death certificate be executed litter death. Director: After this certificate has been signed by the attending physician and in by the tuneral director, page 2 should be detached for use as the burial-transit.		resulting in death) cast	Due to (or as	a consequer	nde of):							
187	physicate t	Physician/Medical		d									
9 x	death certifica attending ph of for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnanc	v					230	. Date of deliv	an/
Вох	death atter	clar	in the past 12 months?	1⊡Live birth 4⊡Pregnant a			Ectopic pregnancy Other (specify)				200	Month	Day Year
P.O.	at the de by the a	hys	9 Unknown	9□ Unknown									
S,	res that igned b	by P	Partil. Other significant conditions of	ontributing to death t	out not resulti	ing in the u	nderlying cause giv	en in Part I.		23e. Did tot	oacco use	contribute to t	he cause of death?
ord	w requir been si should I	ted	in a sers 12) pe i						1 🗆 Ye	es 2 🗆 N	lo 3 ☐ Prol	oably 4 Munknown
ecc	e law r has be ge 2 sh	Completed	VVD							24a. Was a autops	y	prior to co	opsy findings available ompletion of cause of
<u>=</u>	: The l	Con								perform 1 ☐ Yes 2	ned? No	death?	2 🗆 No
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		of Death	(Check only on	е)		
of Vital Records,	Phys r this ral dii	. To	1 ☐ Yes 2 No 27. Manner of Death	1 A Inpati		VOutpatier 8b. Time of	IL SLI DOA	4 Nui		e 5 Reside			fy)
O	ding f th. : After funer	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year)	Injury	Wor	k? Yes 2 □ N		04. 2000.120	, , e., e		
Division	Attendia r death. ector: A by the fu	Ifica	3 Suicide 6 Could not b	e 28e. Place of In	jury - At home	e, farm, str	eet, factory, office		2			lumber or Run	al Route Number,
á	s afte al Dir	Certification;	4 Homicide	bullaing, e	tc."(Specify)					City or Towr	i, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical	29a. Certifier 1 Certifying Ph (Check only one) 1 Certifying Ph	ysicien: To the best niner: On the basis of and manner st	of examination	edge, deatl n and/or in	n occurred at the tin vestigation, in my o	ne, date and pinion, deat	d place, a h occurre	nd due to the ca d at the time, d	ause(s) an ate and pla	d manner as s ace, and due t	stated. o the cause(s)
	Fo the Mithin Fo the Somple	Me	29b. Signature and title of certifier				29c. Licens	e number	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2		igned (Month,	
	/		MU	ben			1000	319	98			16 -	2008
	15		30. Name and address of person who	completed cause of	death (Item 2	За) (Туре,	Print)	1.				Α	an and is at t
3	Sta	te	MITTER JM 31. Date filed (Month, Day, Year)	32. Regist	rar's Signatur	non/	116	eler,	H	my 1	110	0 1.400	vapolis Mi
	Registr		JAN 1 8 200	32. Regist	, St.	Goo	de la						

DHMH 17 Rev 1/2001

18. Mother's Name (First, Middle, Maiden Surname)

Marie Edna McMaster

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6218 Taneytown Pike, Taneytown, MD 21787

and 2 should be filed within 72 hours after death with the Maryland eaith and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at ■ Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

11 17. Father's Name (First, Middle, Last)

James Casper Sanders

19a. Informant's Name/Relationship (Type. Print)

Helen L. Sanders, wife

Funeral

Director

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 Department of H Important: If ite any Injury or ott once.		20a. Method of Disposition 1	Removal from State (y)	22.	atory or other h's Ce Name and A	metery 1/1		aneytown, raw Funer neytown,	MD ral Home	7
Physician /Medical	1	23a. Part Enter the disease, or com shock, or heart failure. List only Imme Tate Cause (Final disease or condition resulting in death)	plications that caused the one caus on each line. a. Due to (or as a core				ac or respiratory arrest,		Approximate Interval Betwo Onset and De	/een
by sician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con	in Soul (deme	entia en e				
the death certific	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 🗆	Ectopic pregn Other <i>(sp</i> ec <i>if</i>			23d. Date of deli Month	,	ear
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours alter death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by P	Part II. Other significant conditions of Colom Can Non In Si	*	_		-	23e. Did tobacc 1 ☐ Yes 24a. Was an autopsy performed: 1 ☐ Yes 2 ☐	24b. Were au prior to death?	robably 42 or utopsy findings as completion of cau	nknown
ertifica ctor, I	Be	25. Was case referred to medical examiner?					eath (Check only one)			
his o	卢	1 ☐ Yes 2 ☐ No		2 ER/Outpatient			Home 5 ☐ Residence		city) HOSpra	ce.
ath. or: After i ne funera	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation		ar) 28b. Time of Injury		Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred		
s after de	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - building, etc. (Si	At home, farm, stree pecify)	et, factory, of	fice	28f. Location (Street City or Town, St	and Number or Ru ate)	ıral Route Numb	<i>9er</i> ,
24 hour le Funera letely fille	edical (nysician: To the best of my miner: On the basis of exa and manner stated.							1
withir To th	Me	29b. Signature and title of certifier			29c. Lic	cense number	29d.	Date signed (Monti	h, Day, Year)	
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N 10			osain MD	447, E	ast t	lain st	eet Wes	1/14/08 thin the	_ MD 2	VIN 7
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's S		barle	,				
H 17 Rev 1/2	001	OAN L	2000	- No for	THE STATE OF THE S					
				ORI	GINAL					

Amend Item Blease Type of Printing Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

State of Maryland / Department of Health and Mental Hygiene.

Amend Item 3 per dr., g876, 02/16/08dhb Death

Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:53 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Eastwood WICOMICO Gircle 5308 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 08/913/1974 Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 33 Yrs. 6. Sex 1 M 2 ☐ F 5. Social Security Number **Funeral** 222-61-9151 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show SALISBURY 1 Yes 2 □ No WICOMICO Completed by Funeral Director 10g. Citizen of What Country? Eastwood 5 CIrcle or Items 23a Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No BIACK Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DRIVER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) To Be if Health and Mental I ESTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) till Conntary 1-22. Name and Address of Facility -19-08 BENNIE Smi441 917 W. ISAbella St. SAlisbury Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part1. En er the disease, shock, or have failure. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (u. as a consequence of). Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy 2 Fetal death Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by Division of Vital Records, 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 - Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide filled t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Chack only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie DOO LJ=674 d address of person who com leted cause of death (Item 23a) (Type, Print) Divilian St, Salubur T. JYL (Year) 1 2008 32. Redistrar's Signature State Registrar

08-00676 Jason Lynn Sha	n h ol		or Print in B								
		1- For State Registrar	e or maryland	Certifica			a ment	ai i iygici k	Reg. N	. 20	08 0275
Physicia	an/	Decedent's Name (First, Middle,L	ast)					2. Date Monti	of Death		3. Time of Death
Medical Exami	ner	Jason Lynn SHA 4a. Facility Name (if not institution, g	NHOLTZ	1	Lab	Cit. Taran	I anation of	Janu	ary 24, 2	008 4c. County of D	1000 hrs
*		1117 Fry Avenue	give street and number)		. City, Town, or Hagerstown		Death	Ï	Washington	
Funeral			Sex 7. Ag	ge (In yrs. last birth		If Under 1 Year		24Hrs. 8. Dat	e of Birth(M		Birthplace (State or
Director		212-88-9228	X M 2 F	33	Yrs.	Months Days	Hours	Min.	ri1 1	7 1974 Fo	oreign Country) Maryland
-	H	Usual Residence of Decedent	A 2	- 55			٠	<u> </u>		17/7	Haryland
* any		10a. State 10b. County		10c. City, Town	or Location	1					10d. Inside City Limits
land f shov	ē	Maryland Washin	gton	H		stown					1 X Yes 2 No
death with the Maryland or items 23a or 28a-f show	Funeral Director	10e. Street and Number				10f. Zip Code			10g. C	Citizen of What (Country?
with the Mai ns 23a or 28. be notified a	무	1117 Fry Avenue	T40 W - B T-		40.14	217		0/0 1/1		USA	and a Dist
P ≥ S e e	ner	11. Marital Status1 Never Married 2 X Marri	12. Was Deceden Armed Forces	?	If Yes	Decedent of His , specify Cuban	panic Origi , Mexican, I	n? (Specify Ye Puerto Rican, e	tc.)	White, et	merican Indian, Black, c.
fler de			1 X Yes 2 ed If Yes, Give Year 19		1 Y	es 2 X No	specify:			Specify:	White
nore, MD 21215-0036 gees I and 2 should be filed within 72 hours after death not of Health and Mental Hygiene. F. Ifriten 27 is marked other (tan "natural", or ite other fraumatic event, the Medical Examiner must	d by	15. Decedent's Education (Specify		mpleted) 16a. [Usual Occupat			e 16b	. Kind of Busine	
6 172 h an "n cal Ex	lete	Elementary/Secondary (0-12)	College (1-4 or	5+)		t of working life.	. DO NOT u	ise retired)			
5-0036 ed within 72 tygiene. other than	Completed	12 17. Father's Name (First, Middle, La	0	E	lecti	rician	40.14-11-1	Name (First, N			tial electric
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC		,	-						,	
212 212 uld be Ment mark	To B	Charles Franklin 19a. Informant's Name/Relationship	Shanholtz (Type, Print)		. Mailing A	Address (Stree		na Jane per or Rural Roi		City or Town, S	State, Zip Code)
MD d 2 sho lth and n 27 is numati		Buffy Shanholtz	- Wife	Ϊı	117 1	Trv Avei	nue F	lagerst	מער. א	farvlanc	1 21742
more, MD 21215-003 Pages I and 2 should be filed withi ent of Health and Mental Hygiene, unt: If item 27 is marked other th other traumatic event, the Med		20a. Method of Disposition			f Disposition	on (Name of cer	metery,	Date	20	c. Location - Cit	1 21742 y or Town, State
트 교 의 등 등 눈		1 X Burial 2 Cremation 4 Donation 5 Other Spec		late	•	Cemeter	.y	1/29/08	$ $ $ $	lagersto	wn, Maryland
	ı	21. Signature of Funeral Service Lic				me and Address				neral Ho	
	4	Wobert B. K.	nekir								ary1and 21740
Physician /Medical		23a. Part I. Enter the disease, or confailure. List only one cause on		the death. Do no	t enter the	mode of dying,	such as ca	rdiac or respira	tory arrest, s	shock, or heart	Approximate Interval Between Onset and Death
∦ caminer	- 1	Immediate Cause (Final disease or condition resulting in death)	a. Seizure dis								Deali
`		Sequentially list conditions,	b								
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	sequence of):							
-24.	cam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):						- 30.	2.00
cuted and transit			d								
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Box 68760, e death certificate be the attending physicied for use as the buri	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco				Estania	pregnancy		23d. Date of del Month	livery Day Year
x 68 h certi tendin use as	cial	past 12 months?		t time of death 5		Ideath 3 er (Specify)	Ectopic	pregnancy		WOTH	Day Teal
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u	hys	1 Yes 2 No 9 Unkno	9 Oliknown			. , , , _					
.O. that th	by P	Part II. Other significant condition	s contributing to dea	th but not resulting	in the und	derlying cause of	given in Par				te to the cause of death?
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ord aw rec as bee	Completed							248	a. Was an autopsy	prio	re autopsy findings available r to completion of cause of
Rec The I ficate I	팃							1 🔻	Performed Yes 2		Yes 2 No
tal certif	Be (25. Was case referred to medical examiner?	Hospital:				Other	Check only one			
f Vi Physi er this	은	1 ✓ Yes 2 No 27. Manner of Death	1 Inpati		itpatient		ry at Work?	Nursing Home		injury occurred	Other: Scene
nding nding th.	iö Ei	1 Natural 5 Pending	(Month, Day,	Year)	inne or my	· 1 _ ·	Yes 2		SCIDE NOW	injury occurred	
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the safer death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	icat	2 Accident Investig	ation 28e Place of I	njury - At home, fa	rm, street.				ation (Stree	et and Number o	or Rural Route Number, City
Div ital or ral Dir Iled in	Certification:	Suicide 6 Could n 4 Homicide	ot be			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5, -10		Town, State		
Division of Vital Records, P.O. Box 68760, To the Hospital sor Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra		29a. Certifier (Check only 1 Certifying Phys	ician: To the best of n	ny knowledge, dea	th occurre	d at the time, da	ate and plac	ce, and due to t	ne cause(s)	and manner as	stated.
Fo the vithin Fo the	Medical	one) 2 Medical Examin	ner:On the basis of exa and manner stated	amination and/or ir	vestigatio			urred at the tim	e, date and	place, and due	to the cause(s)
- > - 0	Σ	29b. Signature and title of certifier				29c. Licens	e number		29	d. Date signed	(Month, Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a)

2008

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

2008

32 Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 25, 2008

OCME

			1 - For State Registrar	State of N	Maryland /	Depa <i>Cer</i>	artment <i>tificate</i>	of H	ealth a Death	and M		giene Reg. No.	00	8 0276	0
	Physici	an	1. Decedent's Name (First, Middle, I	Last)							2. Date of Dea Month	ith Day	Yea	3. Time of Death	
	/Medio	al	Polly W. Thom		-1						January	15	2008	3 5:10 P	M
	Examin	er	4a. Facility Name (If not institution, g Sunbridge Car		er)		4b. City, To	_{own, or} lkto		of Death		40.0	Ceci		
- 45	Funeral				Age (In yrs. last I	birthday)	If Under 1	Year	If Under 2		8. Date of Birti	n ,		Birthplace (State or Foreign	gn
8	Director		222-50-9023	1□M 2XF	98	Yrs.	Months	Days	Hours	Min.	(Month, Da) May 25		9 No	Country) orth Carolin	a
	pug 🔉		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City Limit	te
	Maryla f sho	o		cil	,,									1 X Yes 2 □ N	
	1 the	Directo	Maryland Ce	CII	1.	E1k	10f. Zip C	Code		-		10g. Citiz	en of What	t Country?	
	th with	al D	1 Price Drive					219	21				USA		
	r dea	Funeral	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S.	13. \	Was Decede f Yes, specif	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	1		American Indian, Vhite, etc.	
36	s afte	by F.	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 □Yes 2 ☐ If Yes, Give Year or Dates	_		I□Yes 2						Specify:		
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent. The Medical Examiner must be motified at	edt	15. Decedent's			Sa. Deced	lent's Usual	Occupa	tion			16b. Kin	d of Busine	White ess/Industry	
212	hin 72 9. Medi	Completed	(Specify only highest g		r 5+)	(Give life. L	kind of work DO NOT use	done di retired)	uring most	of worki	ng			,	
7	ed wit	Соп	6			Не	omemak						n Hom	ne	
and	be file	Be	17. Father's Name (First, Middle, La								(First, Middle,		. ,		
ž	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Exportment must be retilled at once.	ို	Columbus Edwar 19a. Informant's Name/Relationship		10	Ob Mailin	a Address /	Street			e Franc Route Numbe			to Zin Code)	
Z	nd 2 s lith an 27 is :		Clarence W. Ti												
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Ë	Pages nent of I ant: If Its ary or o		1		.0		,			k 1-1	22-08	Vew (last1e	e, Delaware	
Baltimore,	rmit. apartn porta iy inju		21 Ignature f Funeral Service Lic	epsee 7	1.	22	. Name and	Address	s of Facility	v	Home,		.4501	o, peraware	
-	80E # 9		Kechand L.	Cloor	dee	3	18 Geo	rge	Stre	et.	Chesape	ake	City.	MD 21915	
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9 ×	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burral-transit	/Me	IF FEMALE:	23c. If yes, outcom	ne of pregnancy									deli ee	
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ecc	law rias be	Completed		· · · · · · · · · · · · · · · · · · ·		_					24a. Was a		24b. Were	autopsy findings available to completion of cause of	le f
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o	Attending Physician: r death. sctor: After this certifice by the funeral director.	70	1 ☐ Yes 2 No 27. Manner of Death	1 🗆 Inpa		Outpatien Time of		\ <u> </u>	4 X Nui		ne 5 Resid			Specify)	_
on	oding th: :: Afte	at lo	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of In (Month, D	Say Year)	Injury	М	c. Injury Work 1 🗆 Y	? 'es 2 □ N	1		,			
N S	Attendi er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of I	njury - At home, etc. (Specify)	farm, stre	et, factory,	office		2	8f. Location (S City or Tow		Number or	r Rural Route Number,	
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			30. Name and address of person wh	·	•		,						1		
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			For State	State of Ma	rylan					and M	ental Hy	giene		fo. on		
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	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation				-			10	d. Inside C	ty Limits
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	or 283	Director	10e. Street and Number					p Code			Ĭ	•	zen of Wh	at Coun	ry?	
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Maryland	d 2 should be th and Menta 7 is marked traumatic ev	은	19a. Informant's Name/Relationship (19b. Mailir	ng Addres	s (Street a			l Route Numb		r Town, S	tate, Zip	Code)	
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ē,	of H		20a. Method of Disposition	ID	20b. P	Place of Dispo	osition (Na matory or	me of other place	e)	D	ate	20c. Lo	ocation - C	ity or To	wn, State	
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Ĭ	al or Attending F safter death. Il Director After ed n by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ry - At ho . <i>(Specif</i>)	ome, farm, str y)	reet, facto	ry, office		2	28f. Location (City or To	Street an wn, State	id Numbei)	or Rura	Route Nun	nber,
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director A completely filled in by the fi	Me	29b. Signature and title of certifier				29	c. License	number			29d. Da	te signed	(Month, I	Day, Year)	
•	(5)		Mr. no				-	060	390)		1/	15/	20	OB	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year 0530 AM ĺ5 2008 HOMSON /Medical Facility Name (If not institution, give street and number ounty of Death **Examiner** 8. Date of Birth (Month, Day, Year) Aug. 8, 1925 9. Birthpla **Funeral** Months Days Hours Mass. 028-14-4588 82 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Crofton Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or Items 23a 1829 Crofton Parkway Apt. D 21114 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 XNever Married 2 Married 1 ☐ Yes 2 No Specify. Completed by White 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Personell Specialist U.S. Govt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental I Important: If item 27 is marked ot any injury or other traumatic ever once. John Powell Thomson Martha MacFarlane 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kerry G. Thomson / nephew Tuckahoe, NJ 08250 Box 662 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metropolitan Crematory 01/15/08 Alexandria, VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service License 6512 NW Crain Hwy. 20715 Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DISSECTION HORTIC /Medical resulting in death) Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1∐ Yes 2⊠ No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No certificate has 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 **⊠**Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation Iniury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1/15/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 DeNE GLEN BURNIE VITBERG, MD 2106 A. HOSPITAL

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 17 2008

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🕦 🖺 🤮 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Irene Dolores Tanavage 1/14/2008 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Prince George's Cheverly If Under 24 Hrs. If Under 1 Year Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Director 74 Nanticoke, PA 202-26-0888 11/18/1933 Usual Residence of Decedent filed within 72 hours after deeth with the Maryland a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Director Prince George's Hyattsville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or Items 23a U.S.A. 20784 6804 Fairwood Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married ☐Yes 2 Yes, Give 2 📆 No 1 ☐ Yes 2X No Specify: Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H tem 27 Is marked oth Be Stanley F. Ruda Mary Piniazek 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra Simon J. Tanavage, Husband 6804 Fairwood Rd., Hyattsville, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages ment of P ent: If ite 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/17/2008 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Dasch damu Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do of other the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aortic Aneurysm /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I my leading immediate cause. Enter Underlying Cause (Disease or injury Due to [or as a consequence of] Examine sicion and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physicien Physician/Medical the as guipt 980 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant atten for u 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Hypertension 1 ☐ Yes 2 ₺ No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2⊠ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 11X Yes 2 □ No 2 1 🔲 Inpatient 2K ER/Outpatient 3 DOA this After thi 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural deeth. 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide ö within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO D0050951 lyne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Reva Gill, MD 6510 Kenilworth Ave., Suite 2400, Riverdale, MD 20737 31. Date filed (Month, Day, Year) JAN 17 Registrar's Signature 2008 State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician Mary Twilley 15, 2008 1:00 A January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Snow Hill Worcester Harrison Senior Living If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**₹** M 2 □ F 95 Director 214-46-4561 Dec. 14, 1912 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2X No Director MDWicomico Pittsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9049 Gumboro Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 🖄 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White ρ, 3 ₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlton Della ပ Dryden Givens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is any Injury or other trainonce. 9049 Gumboro Road Pittsville, MD 21850 Grace T. Disharoon-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pittsville Cemetery 1/18/2008 Pittsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home 705 E Main St. Salisbury, MD 21804 23a. Part1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, physician Physician/Medical the as been signed by the attending should be detached for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death Division or Vital Records, P.O. 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ater death. 1 Natural 5 Pending investigation after death.

i Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1-15-2008 54422 SARAD m 30. Name and address of person who completed cause of death (Item-23a) (Type, Print) 2185 Mank ocon 31. Date filed (Month, Day, Year) egistrar's Signature State JAN 17 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James Barry Verdier 200 8 /Medical CVOI 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 12968 Greensburg Road Smithsburg Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 □ F Days Hours 220-54-3901 57 Director June 7, 1950 Pennsylvania Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Washington Directo Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12968 Greensburg Road 21783 U.S.A. Funeral should be filed within 72 hours after death nd Mental Hygiene. marked other than "natural", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White the Medical 15. Decedent's Education (Specify only highest grade com 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Richard Earl Verdier Sadie Isabel Lohman and l 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health at Important: If item 27 Is any Injury or other trau Brian M. Verdier 12968 Greensburg Rd. Smithsburg, Maryland 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State January Science Care 4 ☐ Donation _ 5 ☐ Other (Specify) 29, 2008 Aurora, Colorado 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home M01414 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each the. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of): Physician/Medical as for use IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 □Unknown 1 □ Yes 2 No certificate has been si rector, page 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform 2□ No Division or Vital 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 1 Yes ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this (28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation (Month, Day Year) Injury Natural To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) State 2008 FEB 0 Registrar

			For State Registrar		State	of Mar	yland / Dej <i>Ce</i>	oartmer e <i>rtificat</i>				_	giene Reg. No.	200	18	0276	6
			Decedent's Name (First	t, Middle, Las	t)							2. Date of De	eath			3. Time of Death	
	Physici /Medio		J	ames S.	Wilson							Month January	Day 13		ear 008	1657 N	l
	Examin		4a. Facility Name (If not in	stitution, give	street and nu	umber)		4b. City,	Town, or	Location	of Death		4c.	County of E	Death		
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	Funeral Director		149-14 9916		x M 2□F	7. Age	80 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da April 1!	ay, Year)		Counti	ace <i>(State or Foreig</i> y) ersey	п
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	faryla shov ed at	٥		County			roc. City, Town or	Location							10	d. Inside City Limits 1 ⊠Yes 2 □ No	
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	ems 2	Funeral	11. Marital Status		12. Was Dec	cedent Ev	er in U.S. 13	B. Was Dece	dent of Hi			cify Yes or No Rican, etc.))-	14. Race - A Black, V	America		
30	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	by Fu	1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ D			2 ☐ No live	WWII	1 ☐ Yes		Specify.					,	n-American	
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7	ed wil ygien her th	Con				· <u>+</u>	l l	blic Ad	minis					ocal Go	vern	ment	
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Ξ.	should nd Me mark matic	ဥ	James Shen			r.	19b. Ma	iling Address	(Street a	and Numb		irginia I Route Numb		r Town Sta	te Zin (Code)	
<u>8</u>	nd 2 saith ar 27 is r trau		Phyllis C.					_				, Bowie				, ode,	
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Ĕ	Pages ment of ant: If ite	,	1 ⊠ Burial 2 □ Cren 4 □ Donation 5 □ C			1 State	Gate of I	-	-	1	01/18/	2008	Silv	er Spri	ing,	Maryland	
Baltimo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Euneral S	Service Licens				22.Name ar Hines-R 11800 N	inald:	i Fune	ral Ho	ome, Inc	ver St	nring.	Marv	land 20904	
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×	death certifica attending ph d for use as t	M/u	IF FEMALE: 23b. Was decedent pregn	ant	23c. If yes, ou	utcome pf		- Catonio n					2	23d. Date of	deliver	y	Į,
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	Physician/M	in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	s?		mant at tir		⊟Ectopic p □ Other <i>(s</i>						Month		Day Year	
	that the ed by detac		Part II. Other significant of	conditions co	ntributing to o	death but	not resulting in the	underlying o	ause give	en in Part I	l.	23e. Did t	obacco u	ise contribu	te to the	cause of death?	
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200	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ 2 ☐ Accident	Pending investigation	(Moi	nth, Day \	<i>(ear)</i> Injury	М	Work	<br Yes 2 □				,			
<u>2</u>	ir Atte	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place	e of injury ding, etc.	- At home, farm, s	treet, factor	, office		2	8f. Location (a City or To			r Rural	Route Number,	
ב	pital cours af		29a. Certifier th⊠ C	ertifying Phy	reinian. To th	a bast of	mu knowlodgo do	ath occurred	at the tim	no data a	nd place, a	and due to the	=====(=)	l and man		A = 4	Ü
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2.	Medical	(Check only 2 M	edical Exam	iner: On the I	basis of e	my knowledge, de xamination and/or d.	Investigation	, in my op	pinion, de	ath occurre	ed at the time,	date and	d place, and	due to	the cause(s)	
)	To To	2	29b. Signature and title of	certifier			-		i. License		7-		29d. Dat	te signed (M	fonth, D	ay, Year)	
	10		30. Name and address of				th (Item 23a) (Type	e, Print)	ندسا	Y 5	had	10001	SW	10	21	2008	
	Sta	te	31. Date filed (Month, Day		1		s Signature	1	۵								
	Registr	ar	UNIT	4 6 6	000	A STATE	1 10. V	The state of the s									

DHMH 17 Rev 1/2001

		_	For Stete Registrar		Maryland / Depa	artment <i>rtificate</i>					Reg. No.	008	02767
ſ	Physici		1. Decedent's Name (First, Middle, Last Melvin Urublewski							2. Date of Dea Month anuary	Day	2008	3. Time of Death 06:00 Å M
	/Medio Examin		4a. Facility Name (If not institution, give		r)	4b. City, T	own, or	Location o		andice		nty of Death	00.00 A
		•	803 A Almond Cour			Bel					Har	ord	
	Funeral Director		5. Social Security Number 6. Se 6. Se 7. Security Number 7. Security Number 8. Security Number 9. Security N	X M 2□F	Age (In yrs. last birthday)	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day June 1,	7. Year) 1929	9. Birth	place (State or Foreign ntg/) (CCL
	Maryland f show	or	10a. State 10b. County Maryland Harford		10c. City, Town or Le	ocation							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-	irect	10e. Street and Number	·	nec not	10f. Zip C	Code				10g. Citizen	of What Cou	ntry?
	th with	ai D	803 A Almond Court			2101	4-2	677			U.S.A	•	
980	be filed within 72 hours after death with the Maryland hat Hygiene. Id other then "natural", or Items 23e or 28e-f show event, if a Madical Exertified at	l by Funerai Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🌠 Divorced	12. Was Deceder Armed Forces 1 Ares 2 If Yes, Give Year or Dates	No 1950-	Was Decede If Yes, specif 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		Race - Ameri Black, White, acify: Whi	etc.
21215-0036	within 72 ho ne. than "natu e Mullo	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-40	r 5+) (Give	dent's Usual kind of work DO NOT use	done d retired)	<i>uring</i> most		g		f Business/Ir L Serv	•
	e filed within at Hygiene. I othar than 'vant, I'r Me		17. Father's Name (First, Middle, Last)	4	Etec	trical				(First, Middle,			ace
Maryland	should be and Mental marked o	To Be	Roy Wrublewski	Orien)	405-14-17	- 411			ie T		O't T-		- Codel
Mal	d 2 sh th and th sun traun		19a. Informant's Name/Relationship (T) Charlotte L. Bown		. 1	-				Route Numbe		_	
Baltimore,	ages 1 and 2 should ont of Health and Mer it: If item 27 Is marke y or other traumatic		20a. Method of Disposition 1 □ Burial 2 ② Cremation 3 □ f 4 □ Donation 5 □ Other (Specify,	Removal from Stat	20b. Place of Dispo	osition (Name matory or oth	e of ner place	9)		ate	20c. Locati	on - City or T	
Baltir	permit. Pages 'Department of H Important: If ite any injury or ot		21 South of Funeral Service Licens		N.A. 100	2. Name and	Addres						P.A. e, MD 21078
		1	23a. Part1. Enter the disease, or comp shock, or heart failure. List enty	ications that caus	ed the death. Do not en	ter the mode	of dying	, such as	cardiac or	respiratory ar	rest,	Out	Approximate Interval Between
	Physician /Medical Examiner)	Immediate Cause (Final disease or condition resulting in death)	a	Bladde as a consequence of):								Onset and Death
8760,	ate be executed hysician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to for a	is a consequence of):								
P.O. Box 68	death certific e attending p ed for use as	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 Fetal death 3 at time of death 5	⊒Ectopic pre ⊒ Other (spe					23d.	Date of deliv	rery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	ntributing to death	but not resulting in the u	ınderlying cai	use give	n in Part I.		UL.		contribute to to	the cause of death?
Il Records,	The te h	Completed					<u> –</u>						opsy findings available ompletion of cause of
Vital	rding Physician: Th th. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	r		(Check only o			
of	Phys r this aral di	.: To	1 Yes 2 No	28a. Date of In	tient 2 ER/Outpatie	and the second second	c. Injury Work	4 🗀 NUI	The same	ne 5 Aesid 8d. Describe I			fy)
ion	Attanding ir death. ector; After by the fune	atio	1 Natural 5 Pending investigation	(Month, E	Day Year) Injury	М		:? /es 2 ☐ l	No				
Division	2 9 2 -	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of I building,	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory,	office		2	8f. Location (S City or Tox		m <i>ber or Rur</i>	al Route Number,
	To the Hospital or At within 24 hours after or To tha Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Example 1	sician: To the besiner: On the basis	st of my knowledge, dear of examination and/or in stated.	th occurred a evestigation, i	t the tim	e, date and pinion, deat	d place, a th occurre	nd due to the d at the time,	cause(s) and date and pla	I manner as s ce, and due t	stated. to the cause(s)
	To the To the Comp	M	29b. Signature and title of contilier	. //		ŀ		number	-			gned (Month,	
	t.		(Whenth	Luni	verin 20			544			Jane	wry 2	1,2005
4	41VA		30. Name and address of person who c	inavolution	death (Item 23a) (Type,	L'Ave	ne	*310	B	le Air	, mid	2101	4
	Sta Registr		JAN 2 2 200	8 September 18	death (Item 23a) (Type, 4B Nev+ strar's Signature	ule							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state State Registrar Amend 28d & 28e, per ME, g 876, 2/28/08 Gertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Welch Sr. Н. 2008 Roger 1,50 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WICOMICO Peninsula Center REGIONAL SAUSHIM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 214-42-8626 1**X** M 2 □ F 64 12/30/1943 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31348 Zion Road 21849 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced white 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) carpentry instructor education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilson H. Welch Nannie Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Welch/wife 31348 Zion Rd., Parsonsburg, MD 21849 20b. Place of Disposition (Name of cemetery, crematory or other place Wicomico Memorial Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 1/18/08 Salisbury, MD Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 (Out Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1 da intruction a Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)

Physician /Medical Examiner

and

attending physician for use as the buria

Physician

/Medical

Examiner

10a. State

Funeral

Director

23a or 28a-f show

items

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any linjury or other traumatic event once.

the Medical

Examiner must be notified at

Director

Funeral

à

Completed

Be

2

with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Completed Be P

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 25. Was case referred to medical examiner? 27. Manner of Death Certification:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

1 Yes 2 No

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

1 Inpatient

9 Unknown

2 ER/Outpatient 3 DOA

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 200 No 3 ☐ Probably 4 ☐ Unknown

Year

24a, Was an autopsy 26. Place of Death (Check only one)

1 Tes

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred subject fell off . Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 5 Pending investigation l*a*dder 1 ☐ Yes · > 8 1200 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At hon building, etc. (Specify) - At home, farm, street, factory, office determined 31350 ZION RD PARSONSBURG, MD yard

1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 2 Medicai Examiner: nd ma stated 29b. Signature and title of certifier

29c. License number

Quisbu.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) the riversite

CHIN

State Registrar 31. Date filed (Month, Day, Year)

UN

JAN 18 2008

32 degistrar's Signature

i Director: After t d in by the funera

within 24 hours aft To the Funeral Di completely filled in

Medical

			For	State o	f Marylan	-	artment of H		and Me	ental Hygi	ene	2000	0076
			1 - State Registrar			Cer	rtificate of	Death		Re	g. No.	2008	02769
	Physici	an	Decedent's Name (First, Middle, L.							Date of Death Month	Day 15	2008ear	3. Time of Death
N.	/Medic		Aline Praither	Willia			# 63 T			January		2008 unty of Death	5:30a ^M
	Examin	er	4a. Facility Name (If not institution, g Manor Care Nursing		mber)		4b. City, Town, o					ntgomer	v
	Funeral			Sex Itolic	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2	24 Hrs.	8. Date of Birth		9. Birthr	lace (State or Foreign
	Director		577-24-9931	1□M 2 ½ F	100	Yrs.	Months Days	Hours	Min.	07/17/19	907	Wash	ington, DC
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c City	y, Town or Lo	cation					1	0d. Inside City Limits
	faryla shov ed at	o,	,										1. Tyes 2 □ No
	the N 28a-f notifile	Director	D.C. 10e. Street and Number		W	ashing	10f. Zip Code			10	og. Citizer	n of What Cour	ntry?
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notifled at	Ö	140 Longfellow	Street,	N.W.		20011				USA	A	,
	death ms 2 r mus	Funeral	11. Marital Status		edent Ever in U.	S. 13.	Was Decedent of H If Yes, specify Cubi	Hispanic Original	gin? (Spec	cify Yes or No-	14.	Race - Americ	
٩	after or ite mine	Full	1 ☐ Never Married 2 ☐ Married	1 Yes	2K No		irres, specily cub 1 □ Yes 2⊠ No	Specify:	i, Puerto F	iicari, eic.)	Sr.	Black, White, Dec <i>ify:</i> B1	etc. Lack
	ours ural", I Exa	d by	3 ☐ Widowed 4 🔀 Divorced	Year or D	ates:	200							
21215-0036	n 72 h "nati edica	Completed	15. Decedent's (Specify only highest of	rade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most	t of workin	g	16b. Kind	of Business/In	dustry
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מ	should be filed nd Mental Hygi marked other imatic event, t	Be C	17. Father's Name (First, Middle, La	st)		I		18. Mothe	r's Name	(First, Middle, N	laiden Su	ırname)	
Maryland	ould be Mental arked o	TO B	Rezin Praither					E1	la Bu	utcher			
ary	s 1 and 2 should I of Health and Men item 27 is marker other traumatic		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	and Numbe	er or Rural	Route Number,	City or To	own, State, Zip	Code)
	and		E. Marlene Tolson	ı – Daugl	nter	706 1	Nicholsor	St.,					20011
ore	0 0		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from	State 20b. F	Place of Dispo cemetery, crer	sition (Name of matory or other pla	ce)				tion - City or To	
<u>=</u>	: Pag tmen tant: tant:	9	4 Donation 5 Dother (Spe	cify)	For		coln Ceme				_		
Baltimore,	permit. Pag Department Important: II any injury o	0.8	21. Signature of Funeral Service Lic	41 \	Gam		2. Name and Addre						Home 20722
ľ			23a. Part1. Inter the disease, or co shock, or heart failure. List on	molications that of	caused the deat	h. Do not ent	er the mode of dyi	ng, such as	cardiac or	r respiratory arre	est,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to	(or as a conseq								
	LAGIIIIICI	-	Sequentially list conditions,	b. Due to	(or as a conseq	uonoo of):							
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conseq	derice or _j .							
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Box	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	sician/M	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregna birth 2 □Feta		⊒Ectopic pregnanc	N/			23d	d. Date of deliv	
	ed for	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of d		Other (specify)					Month	Day Year
<u>л</u>	at the de d by the etached	Phys	9 Unknown			utation to also us		on in Part I		220 Did toh	2000 1100	contribute to t	he cause of death?
	iw requires that s been signed to should be deta	by	Part II. Other significant conditions Penydra Ti		eath but not less	unting in the u	ndenying cause giv	veii iii Faiti.	•	1 □ Ye			bably 4 □Unknown
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	ding Physician: The lawn. n. After this certificate has funeral director, page 2	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2	EB/Outpatier	ot 3 DOA Oth			(Check only one) ne 5 ☐ Reside		Other (Speci	6.0
Division or	g Phy er this eral d	n: To	27. Manner of Death	28a. Date	of Injury	28b. Time o				8d. Describe ho			
0	nding ath. r: Afte	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat		nth, Day Year)	Injury		Yes 2	No				
NIS.	r Atte er deg recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	J ZOU, FIAUE	e of injury - At ho ing, etc. (Specif	ome, farm, str	eet, factory, office		2	8f. Location (St. City or Town		Number or Run	al Route Number,
ā	ital or rs afte ral Di	Cer											
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral director, the funeral director and the funeral director and the funeral director.	Medical	29a. Certifier 1	aminer: On the b	e best of my kno basis of examina iner stated.	wiedge, deat ition and/or in	h occurred at the ti vestigation, in my	ime, date ar opinion, dea	nd place, a ath occurre	and due to the ca ed at the time, d	ause(s) ar ate and pl	nd manner as s lace, and due t	stated. to the cause(s)
	ro the vithin ro the somple	Me	29b. Signature and title of certifier	- 11	9		29c. Licens	se number		25	9d. Date s	signed (Month,	Day, Year)
	F 17)		1 /ann	de	u		00	253	27	35	11	161	08
	CHO CHO		30. Name and address of person wh	o completed gaus	e of death (Iten					. 1	/ /	20707	
	Sta	ite	31. Date filed (Month, Day, Year)	32. F	Registrar's Signa		Baltimor	ce Ave	nue l	Laure⊥,	MD	20707	
	Regist		JAN 1 7 2008	Kenn !	15 do	ales							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 02770 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 12 Abeth leet man 1457 AN 1008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COCN P0115 If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 21X F 577-12-0847 87 Director 11/16/1920 Washington, D.C. Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2/X No Director MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1010 Simsbury Court 21114 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: Completed by 3 ₩ Widowed 4 Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerical C & P marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental F Be Walter A. Walker Marguerite Louise Walker Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other tree Carol Lee, Daughter 1010 Simsbury Ct., Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/12/08 Alexandria, VA 21. Signaure of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 2078 Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Due to (or as a consequence of): Examiner The law requires that the death certificate be exacuted attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760. Physician/Medlcal that initiated events Due to (or as a consequence of): resulting in death) Last P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed by the straid director, page 2 should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗆 Yes 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Medical Certification: To 4 Valursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred WAIKER 1 Natural 5 Pending after death. Director: Aft tell trom 12/2/07 1 ☐ Yes 2 No 2 Accident investigation LINKM the 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (5 pe ify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 6 10 me roston Hospitel 29a. Certifier 1🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the Deputy 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed (auge of death (Kem 23a) (Type, Print) 3 mD pres 31. Date filed (Month, Day, Year) State 2008 7 Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 1218pm James Maury Werth 2003 unuar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington Hagerstown 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Yea) Birthplace (State or Foreign Country) New York 5. Social Security Number **Funeral** 1 M 2 □ F Months Days Hours Min. 90 Sept. 15, 1917 Director 224-50-5646 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Directo Williamsport Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Avenue 21795 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ★1 Yes 2 □ No If Yes, Give Year or Dates: WW | | 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Captain Militarv 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pauline Bogardus ဂ James Rhodes Werth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Portsmouth</u>, Virginia <u>153 Crawford Parkway</u> <u> James A. Werth - Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan.23,2008 Hagerstown, Maryland Rose Hill Cemetery Funeral Service Licensee 21. Elgnatur OSBOTTE HOME, P.A. 425 S. Conococheague St. Williamsport, Maryland a a fift. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** (NUTE ENIMIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Clie to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown ate has been signed I page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an 1☐ Yes 2 Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 1 Inpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Maryner of Death 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural s after death. I Director: A d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I completely filled Two Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

5H-15+1 State

> Registrar DHMH 17 Rev 1/2001

29b. Signature

31. Date filed (Month, Day, Year, JAN 2

on who completed cause of death (Item 23a) (Tyse

32. Registrar's Signature

ZNOW

2008

3

13424

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrar WCHD/SH 1/23/08 per FH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Maurice Wilbur WALLECH, Jr. January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington County Hospital Hagerstown
1 Year | If Under 24 Hrs. Washington Social Security Number 220 42 5673 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Months 1**X** M 2□ F Hours Min Director 61 26 1946 Jan Marvland Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location show 10d. Inside City Limits r 28a-f show notified at Director 1▼ Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n Funeral 610 George Street 21740 USA 'naturai", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2K No δ Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) is marked other than 10 Technical Engineer City Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Maurice Wilbur Wallech, Sr. Margaret Louise Rowe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i June Wallech - Wife 610 George Street, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: if it any injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Cedar Lawn Mem. Park 1/24/08 Hagerstown, Maryland 21. Signature of Fineral Service Lip 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a on line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of) Examiner on rayor if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the death certificate be executed that initiated events resulting in death) Last burial-tra Due to lo las a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Ö 9 I Inknown 9 Unknown <u>م</u> Part II. Other significant conditions contribu th but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ respec 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performe Sepsis certificate Division or Vital 2 No 25. Was case referred to medical (examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 | Yes 2 | 1 | No 1 Hipatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury 1 □ Yes 2 □ No death. 2 Accident after death

Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral I Hospital 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and fitle of certifier 29d. Date signed (Month, Day, Year) DOUY1131 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEPR 5H-K COPPECES

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 2008 anyary 4b. City, Town, or Location of Death 8. Date of Birth (Month, Day, Year) 4/17/1926 7. Age (In yrs, last birthday If Under 1 Yea If Under 24 Months Min 1 □ M 2X F Days Hours 81 10c. City, Town or Location

1. Decedent's Name (First, Middle, Last) Physician Lois Irene Amos /Medical 4a. Facility Name (If not institution, give street and number) Examiner MOr 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 215-22-3944 Director Pennsylvania Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2√2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane, S120 21228 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼No Specify: Specify: White 3 Widowed 4 □ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Burget Frances Franz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a William C. Amos / Son 9255 Hobnail Court, Columbia, MD 21045-4006 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or Bayview Crematory 2/4/2008 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HubbardFuneral Home, 4107 Wilkens Avenue, Bltimore, MD 21229 23a. Part : Inter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician hronic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months2 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) ∐Yes 2. SHo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation ■Natural Iniury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier (Check only one) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29d Date signed (Month, Dav. Year)

the death certificate be executed Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica

3altimore, Maryland 21215-0036

State Registrar

31. Date filed (Month

Marden

completed cau

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 2008 Day 24 Margaret Rebekah Bain Jan.

10f. Zip Code

7. Age (In yrs. last birthday,

10c. City, Town or Location

Baltimore

78

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Baltimore

10:00ALM

Birthplace (State or Foreign Country)

Maryland

10d. Inside City Limits

1 X Yes 2 No

4c. County of Death

10g. Citizen of What Country?

N/A

21,1929

8. Date of Birth (Month, Day, Year)

Sept.

a
Physician
/Medical
Examiner

1 - For State Registrar

10a. State

214-26-8841

Usual Residence of Decedent

Maryland

10e. Street and Number

4a. Facility Name (If not institution, give street and number)

Levindale Nursing Home

 $A \setminus N$

10b. County

1 ☐ M 2 ☐ ME

Funeral Director

the Maryland or 28a-f show be notified at

	h witl 23a o st be	a D	2907 Woodland Avenue	21215	USA
215-0036	ges 1 and 2 should be filed within 72 hours after death with to f Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Items 23a o or other traumatic event, the Medical Examiner must be	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc	or No- 14. Race - American Indian, Black, White, etc. Specify: Black
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Maryland	ould be filed Mental Hygi arked other atic event, t	To Be C	17. Father's Name (First, Middle, Last) James Logan Jenkins, Jr.	18. Mother's Name <i>(First, Mi</i> Adah Killi	ddle, Maiden Surname) ON
	1 and 2 should the Health and Men em 27 Is markenther traumatic		19a. Informant's Name/Relationship (Type. Print) Logan Mitchell, Sr. 33	o. Mailing Address <i>(Street and Number or Rural Route N</i> 24 Ingleside Avenue B	umber, City or Town, State Zip Co 2 1215 altimore, Maryland
Baltimore,	Pages 1 and the part of He part: If Item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	of Disposition (Name of try, crematory or other place) cus Memorial Park	20c. Location - City or Town, State Arbutus, Maryland
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of FacilityChatman 5240 Reisterstown Ro	-Harris Funeral Home Baltimore,Md 21215
	Physician /Medical	-		-multifactional	Approximate Interval Between Onset and Death
	Examiner		Due to (or as a consequence	or):	
	P #	iner	Sequentially list conditions, Due to or as a conse uence cause. Enter Underlying Cause (Disease or injury	of):	
	xecute and II-trans	xam	Cause (Disease or injury that initiated events resulting in death) Last C	of):	
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.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ XHO 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
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Vita	sician certifi irector	Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Ou	26. Place of Death (Check of utpatient 3 DOA Other: 4 Nursing Home 5	
יס ר	nding Physician: The law th. r, After this certificate has b e funeral director, page 2 sl	tion: To	27. Manner of Dath 28a. Date of Injury 28b.	Time of Injury at Work? 28d. Description	ribe how injury occurred
sion	tendir eath. tor: Ai the fu	catio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	
Division	al or At s after d al Direc ed in by	Certifica	3 Suicide 6 Could flot be 4 Homicide determined 28e. Place of injury - At home, fa building, etc. (Specify)		ion (Street and Number or Rural Route Number, or Town, State)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical (e, death occurred at the time, date and place, and due to nd/or investigation, in my opinion, death occurred at the	
.	To the within to the comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	7		30. Name and address of person who completed cause of death (Item 23a)	(Typel, Print) 2 2 / // D /	~ / D ~ 2 12 17
1	,		31, Date filed (Month, Day, Year) 32. Registrar's Signature,	2739 W 15-610	1047 2141)
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		=	Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death		
	Physici /Medio		Frank Augustus Bell		Jan. 25,	2008 2110 M	
	Examir	4.1	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death			
			Carroll Hospital Center	Westminster		Carroll	
	Funeral		5. Social Security Number 6. Sex 1 ₩ 2 □ F 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	M. (Month Day Oga	9. Birthplace (State or Foreign Country)	
	Director		220-18-4770 96 Usual Residence of Decedent		Mar. 9,	1911 Maryland	
	land ow		10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits	
	Mary -f sh fied a	ţō	Maryland Baltimore Reister	rstown		1 □Yes 2□No	
	h with the 23a or 28a st be notii	Funeral Director	10e. Street and Number Cantata 304 Cantat Court Apt. 212	10f. Zip Code 21136		Citizen of What Country? USA	
21215-0036	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at		1 □ Never Married 2 □ Married 1 □ Yes Sa □ No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☎ No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black	
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lanc	be do la	To Be	Herman Bell	1	essie Der	*	
Maryland	d 2 shouth and Ivanian Ivanian		19a. Informant's Name/Relationship (Type. Print) Anna Bell/ Wife 19b. Mailin 304	ng Address <i>(Street and Number or Ru</i> Cantata Court	ural Route Number, Cit Apt. 212	ty or Town, State, Zip Code) 21136 Reisterstown, Md	
d)	Pages 1 and 2 should nent of Health and Mer int: If Item 27 is marke iny or other traumatic		20a. Method of Disposition 1	osition (Name of matory or other place) .M. Methodist	1 ^D 7 ¹⁰ 08 Cem.C	Location - City or Town, State Cockeysville, Md	
Balt	permit. Pages: Department of I Important: If Ite any Injury or of		21. Signature of Funeral Service Liousee 25	2. Name and Address of FacilityCha 240 Reisterstown	atman-Har wnm , Ba	ris Funeral Home Iltimore, Md 21215	
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	/Medical		resulting in death) a. Due to (or as a consequence of):	01 - 11			
	Examiner		Sequentially list conditions by C. V. A.				
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Atmal Fib	Allaha	A ma	
	ecute and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	MANIAX 110	24 (1441)	<u> </u>	
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587	ficate phys	edical	d				
O. Box	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as it.	Physician/Me		□Ectopic pregnancy □ Other (<i>specify</i>)		23d. Date of delivery Month Day Year	
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Records,	ne law require has been si ge 2 should b	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?	
Vital		е Со	25. Was case referred to medical	26 Place of Do	ath (Check only one)	HO 1 ☐ Yes 2 ☐ No	
5	Physician: this certific	00	examiner? 1 Yes 2 100 Hospital: 1 Umpatient 2 ER/Outpatien	Other:		e 6 □Other (Specify)	
ō		n: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 1997.		28d. Describe how in		
ion	Attending or death. ector: After by the fune	ațio	2 Accident investigation	M 1 Yes 2 No			
Division	i i it o	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)	
Ц	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier (Check only 2 ☐ Medical Examiner: On the basis of examination and/or in				
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	one) and manner stated. 29b. Signature and title of certifier				
			the cone	D-005	7218	enmy by MD	
2	Y		30. Name and address of person who completed cause of death (Item 23a) (Type, DR PAMAN B KAN CRA)	349 Malenima	luve, W	entminter MD	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 4 2008 Registrar's Signature	red 1		/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 20b, perFh,g876, 2/4/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 09291 Brown LOC-2002 /Medical 4a. Facility Name (If bot institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** lto Jax VIEW home City Imore (If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days **X**□M 2□F Hours 219-05-0374 87 Director 10/31/1920 MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 ☐ No Director BALTIMORE CITY MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 21239 USA 1336 SHERWOOD AVENUE Funeral ural", or items ? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Be Completed by WHITE 3 Widowed 4 Divorced "natural", is 1 and 2 should be filed within 72 hoff Health and Mental Hygiene.
I tem 27 Is marked other than "naturother traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WESTERN ELECRTIC MACHINIST 10TH_GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES BROWN ၉ NETTIE BEYER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 Is DOROTHY DIMICK/DAUGHTER 7300 KIRTLEY ROAD BALTIMORE, MD 21224 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
DULANEY VALLEY MEM.
GARDENS 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 6 permit. Page Department o Important: If any injury or 4 Donation 5 Other (Specify) TIMONIUM, MD 21. Sig true of Funeral Service Licenses 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List phly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: for use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed k Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1∐ Yes 2 🖾 No Physiclan: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 XER/Outpatient 3 ☐ DCA Medical Certification: To 1 ☐ Inpatient this 28a. Date of Injury (Month, Day Year) Magner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Hospital or Attending 1 🔀 Natural 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident death 24 hours a er dear e Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 🕝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manaer stated. (Check only one) within 2 29b. Signature nd title of certi 29c. License number 29d. Date signed (Month. Day, Year, 0 WMIMA.

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

()1

30. Name and diddless of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrar's Signature

Year

08-00734	
Ryan Bell	

yan Bell	State of Maryland / Department of		ygiene	00 0033	
	1- For State Registrar 1. Decedent's Name (First, Middle,Last)	Death	Reg. No.	3. Time of Death	
Physician/ ledical Examiner			Month Day Year January 26, 2008	2151 hrs	
	Ryan Keith Bell 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		eath	
	Laurel Regional Hospital	Laurel	Prince Geo	•	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	- Ec	reign	
Director	287-74-5385 · 1XM 2 F 33 Yrs	Months Days Hours Min	3-15-1974	Country) Ohio	
	Usual Residence of Decedent			10d. Inside City Limits	
w any	10a. State 10b. County 10c. City, Town or Local	ion		1 Yes 2 X No	
Aaryland 28a-f show 1 at once.		Meade 10f. Zip Code	10g. Citizen of What 0		
th the Maryland 23a or 28a-f sho notified at once	10e. Street and Number		, and the second		
ith the state of t	8127 A Packard Ct. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	20755 as Decedent of Hispanic Origin? (Sp	United St pecify Yes or No- 14. Race - A	States ace - American Indian, Black,	
or items 23. must be no		es, specify Cuban, Mexican, Puerto		c.	
fier de fi., or fer mi	3 Widowed 4 Divorced of Tyes 2 No 1 Tyes 2	Yes 2 X No specify:	Specify: P	Black	
hours afte 'natural'', Examiner ted by	45 Days levels 51 settler (C. self section beauty completed) 460 Decedes	nt's Usual Occupation (Give kind of nost of working life. DO NOT use ret		ess/Industry	
6 172 h an "n cal E	Elementary/Secondary (0-12) College (1-4 or 5+)	lost of working me. Do No 1 abo for			
-0036 Unithin 72 hour giene. her than "natu her than e Medical Exan ompleted	12 I	nstructor	U. S. e (First, Middle, Maiden Surname)	Navy	
215-0036 be filed within 7 mial Hygiene. rked other than ent, the Medica	Tr. Factor's Hamo (First, Wildard, Edity)		ria Bell		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Calvin Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailir		Rural Route Number, City or Town, S	State, Zip Code)	
MD d 2 sho lith and n 27 is aumati	Hisayo Bell / Wife 8127	A Packard Ct. Ft	. Meade, Maryland	1 20755	
e, Fe, Ford I and Healt Healt I item	20a. Method of Disposition 20b. Place of Dispo	sition (Name of cemetery,	Date 20c. Location - Cit	ty or Town, State	
Pages nent of lant: 14 or othe	I Buriai 2 La Cremation 3 Removal non State	1 Crematory 2/6	6/2008 Odenton	,Maryland	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	21 Signature of Funeral Service II tensee	Name and Address of Facility	Home & Crematory		
w 89 11 ji	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	1 Annapolis Road	l Odenton, Maryla	nd 21113 Approximate Interval	
Physician /Medical	failure. List only one cause on each line.			Between Onset and Death	
aminer	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive atheorsclero	otic cardiovascular d	lisease	Death	
	b				
Jer Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
amine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
E ansit	d				
ian and	X UNPENDED - #250,27,perME,g877 3/10/	'08 TT			
760, icate be physic the bur			23d. Date of de		
ox 6876 ath certificate attending phy or use as the I	past 12 months? 1 Live birth 2 F	etal death 3 Ectopic pregr https://ectopic.pregr	nancy Month	Day Year	
Box 6876(ne death certificate the attending physel for use as the brosician/Me	1 Yes 2 No 9 Unknown g Unknown	the (opeany)			
P.O. Be sthat the degree by the edetached f	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribu		
ires that signed a be deta			1 Yes 2 V No 3		
Records, F The law requires ficate has been sig , page 2 should be Completed			autopsy pric	ere autopsy findings available for to completion of cause of	
Che law ate has age 2 s				ath? Yes 2 No	
tal Rection: The certificate ector, page	25. Was case referred to medical	26.Place of Death (Check	k only one)		
of Vital Recling Physician: The After this certificate funeral director, page 700: To Be Com	1 Yes 2 No Inpatient 2 V ER/Outpatien			Other:	
n of ding Pl	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of	Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred		
IVISIOF or Attend after death Director: I in by the	Pending Accident Investigation 28e. Place of Injury - At home, farm, str		28f. Location (Street and Number	or Rural Route Number, City	
Division of Vital Records, spital or Attending Physician: The law requiremental Director: After this certificate has been sfilled in by the funeral director, page 2 should Certification: To Be Completed	3 Suicide 6 Could not be determined (Specify)	set, ractory, office building, etc.	or Town, State)	o	
O Till bou		urred at the time, date and place, ar	nd due to the cause(s) and manner a	s stated.	
To the Howithin 24 h. To the Funcompletely	(Check only one) Medical Examiner: On the best of my knowledge, dealf examiner: On the best of examination and/or investig	ation, in my opinion, death occurred	at the time, date and place, and due	e to the cause(s)	
To To	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)	
3	1 (Galanda Ma)	O.C.M.E.	January 27,	2008	
	\$0. Name and address of person who completed cause of death (Item 23a)				
		n Street, Baltimore, MD 21	201		
State		aste i			
Registra	FFR 0 4 2008 Res At A	×2000			

Physician /Medical Examiner **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Division or Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical

2008

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For		State	of Marylar	nd / Depa	artmer	nt of	Health	and I	Mental H	ygiene	9		
For State Registrar							Death			Reg. No	200	8 0	2779
1. Decedent's Nam	e (First, Middle	, Last)							2. Date of D	eath	Non W	3. Time	of Death
Dougla	S	Barne	es	Sr.					Month	C(1 -	8, 200	8 2: 4	72 PM
4a. Facility Name (,	4b. City,	Town,	or Location	of Death	Sulva	40	. County of Dea	th	<u>. </u>
Civista	· Mo	tical	Cont	es	1.0	P	Vata				Cha	rle	.5
5. Social Security N	lumber	6. Sex	7. Age (In yrs.	last birthday)	If Unde Months	r 1 Yea Days		r 24 Hrs. Min.	8. Date of B	Birth	9. Bir	thplace (State	e or Foreign
267-50-	8719	1 ∑ M 2□ F	7	O Yrs.	Months	Days	riouis	IVIII I.			937Was		on DC
Usual Residence of 10a. State	f Decedent 10b. County		10c Ci	ty, Town or Lo	oation							10d Incide	City Limits
		-	100. 01										es 2 No
MD 10e. Street and Nu	Char	tes		Waldo		- 0-1-				10- 0	Vince of Mile of O		
6108 Bi		uzet			10f. Zip	206	0.2			10g. Cr	tizen of What Co	ountry?	
	SOII CC		cedent Ever in L	IS 12				rigin? (S	posify Voc or N	10	14. Race - Ame	rican Indian	
11. Marital Status 1 ☐ Never Marr	ried 2□ Marri	Armed		54	If Yes, spe	cify Cu	ban, Mexica	an, Puert	pecify Yes or N o Rican, etc.)	10-	Black, Whit		
3 ☐ Widowed		If Yes, (Year or	3ive 10	957	1 ☐ Yes	2 X No	Specify	<i>/</i> :			Specify: W	hite	
	15. Decedent	s Education		16a. Dece	dent's Usu	al Occi	upation			16b. K	ind of Business	/Industry	
(Spec		t grade completed	(1-4or 5+)	(Give	kind of wo DO NOT u	ork done se retir	e during mo red)	st of wor	king				
12	oridary (0.12)	Conege	(1-401 04)	Pa	inte	er					Pvt.		
17. Father's Name	(First, Middle, L	_ast)					18. Moth	ner's Nam	ne (First, Midda	le, Maider	Surname)		
Willia	m Henr	y Barne	es				Cla	ara	Moble	у Ве	11		
19a. Informant's N	ame/Relationsh	ip (Type. Print)		19b. Mailii	ng Address	(Stree	et and Numb	ber or Ru	ıral Route Num	ber, City	or Town, State, .	Zip Code)	
Douglas	Barne	s Jr./	Son	wa1a	неа orf,	tnc MD	ote 20	602°	а				
20a. Method of Dis		٥. 🗆 ت		Place of Dispo	sition (Na	me of other pl	ace)		Date	20c. L	ocation - City or	Town, State	
	□ Cremation 5 □ Other (Sp	3 □Removal from ecify)		vard U	Jnive	eri.	tv 1	1/28	1/08	Was	hingto	n, DO	2
21. Signature	unoral Service I	icensee	2/1								ter Fu		
9	Led	All		38	21 1	4t	h Str	reet	NW,	Wash	ington	, DC	20011
23a Part1. Enter t shock, or hea	the disease, or	complications that	caused the deal	th. Do not ent	er the mod	de of dy	ing, such a	s cardiac	or respiratory	arrest,		Approxin	nate Between
Immediate Caus disease or con tio	Final		. 3		40		1	1.	0 . 0			Onset ar	nd Death
resulting in death)	A1	a. ue t	c (or as a consec	uence of):	110	al	0	45	ear.				
		n 11	rance	101	SEL		24.0	ai	/ estess	. 20	i cons		
Sequentially list confianty, leading to incause. Enter Under Cause (Disease or	inditions, imediate	Dus t	(ur as a consec	juence of).					/	y ec	A resident		
that initiated events	S	c/	wout	Ca					-				
resulting in death)	Last	Due to	o (or as a consec	uence of):									
	,	d											
IF FEMALE:		1	-	-									
23b. Was deceden			utcome pf pregn		∃Ectopic p	regnan	cv				23d. Date of de	,	V
in the past 12 1 ☐ Yes 2 [□No	4□Pre 9□Unk	gnant at time of one	death 5	Other (s)	pecify) .					Month	Day	Year
9 Unknown													
Part II. Other signi	ticant conditio	ns contributing to	death but not res	suiting in the u	nderlying o	ause g	iven in Part	I.			use contribute to		
									IX.	Yes 2	□No 3□P	robably 4	Unknown
									24a. Wa	s an opsy	24b. Were a	utopsy findin completion o	gs available
									per 1∐ Yes	formed?	death?		
25. Was case referexaminer?	rred to medical			~ *			26. Plac	e of Dea	th (Check only				
1⊠Yes 2□	No	Hospital: 1	∭npatient 2 [∑	ER/Outpatier	nt 3□ D0	DA O	ther: 4□N	lursing H	ome 5□Re	sidence	6 ☐Other (Spe	ecify)	
27. Manner of Deat 12 ✓ Natural	th 5 □ Pending		e of Injury onth, Day Year)	28b. Time o Injury	f :	28c. Inj	ury at		28d. Describe	e how inju	ry occurred		
2 Accident	investiga	ation	,,,	.,,.,	М]Yes 2□]No					
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi	20e. Plac	ce of injury - At h ding, etc. (Speci	ome, farm, str	eet, factor	y, office	Э			(Street al	nd Number or R	ural Route N	umber,
		V	,							,	- <i>,</i>		5
29a. Certifier (Check only	1 ☐ Certifying	Physician : To the xaminer : On the	ne best of my kno	owledge, deat	h occurred	at the	time, date a	and place	, and due to th	e cause(s) and manner a	s stated.	0(e)
one)	- Edmourour L		nner stated.	2001 0110 01 11	Tooligation	.,	opinion, de		med at the time	e, uate an	u piace, and uu	e to the caus	G(S)
29b. Signature and	title of certifier	2. 1 m	euni		29	c. Licer	nse number	~		29d. Da	te signed (Mon	th, Day, Year)
1	1	1			1	0	88	ک		11	1281	200	8
30. Name and add	ress of person v	vho completed ca	use of death (Iter	n 23a) (Type,	Print)	t	1.	. 6	7 1 1		1 ,		. (
Vahia	Tago	uri M.	0 254	500	t. 1	Loc	Kouz	t K	d.h.	ean	and to	wn.	ma.
81. Date filed (Mon	th, Day, Year)	2002	Registrar's Signa	ature								200	50

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2330 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Braddock Allegano Campus Year If Under lar 6. Sex Date of Birth (Month, Day, Year) -14-1951 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 **X**M 2 □ F Keyser, 233 84 1072 Director WV Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 NiNo Director Grant Mt. Storm WV 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HC 76, Box 314 26739 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1X∓Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Petersburg Department of Health and Mental Hygiene Important: If Item 27 Is marked other than any Injury or other traumatic event, the Me once. Flementary/Secondary (0-12) 2^{College (1-4or 5+)} Custodian Elementary School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Wilson Bobo Jessie Hilda Hanlin Bobo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 76, Box 314 - Mt. Storm, WV Jessie Bobo - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Locust Grove Cemetery 1-26-2008 Mt. Storm, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility POB 400 Basagic Funeral Home Petersburg, WV 26847 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a Metastatic Non Small Cell Carcinoma of 200 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). sician and Examir The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s autopsy performed? Yes 2 17 No certificate 1□ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To nours after death.

neral Director: After this

filled in by the funeral di After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day 5 Pending investigation 1 TYes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C To the Hospital CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

10

State Registrar

FEB 0 4 2008

Damar Zaman

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Drive Cumberland Maryland 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Robert L. Balsamo 0909 AM 28 2008 bouaru 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death altimore Hospita Hans 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 217-24-8102 MD Jul 11, 1930 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No MD **Baltimore** Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1176 Newfield Rd. 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Salvatore Balsamo Diana Franzoni 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Balsamo Spouse 1176 Newfield Rd. Gwynn Oak, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 DBurial 2 □Cremation 3 □F 4 □Donation 5 □ Other (Specify) 3 □Removal from State Jan 31, 2008 Woodlawn Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MU1015 23a. Part1. Enter the distate, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocholiul MKNOWN Due to (or as deconsequence of): Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2 □Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☑Unknown Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an 2 1 No

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

show

7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified

72 hours after

filed within 7 Hygiene.

1 and 2 should be

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permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
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Baltimore, Maryland 21215-0036

/Medical

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requires that the death certificate be executed ending physician and r use as the burial-tran

Box 68760 Robert

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Examiner

Be Compl 25. Was case referred to medical examiner? 2 № No 1 Tyes 27. Manper of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

31. Date filed (Month, Day, Year)

ian/Medical Medical Certification: To

	att	9	
	director: After this certificate has been signed by the att	In by the funeral director, page 2 should be detached for	
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To the Hospital within 24 hours a To the Funeral Completely filled Hospital 0

State Registrar

0 4

5 Pending investigation

6 ☐ Could not be

29b. Signature and title of certifie Ni 29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

3□ DOA

26. Place of Death (Check only one,

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) anny 28, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) st. Agnes Huspital goo Cater Avenue Baltimure, Maryland 4229 ZUK, MD

₫32. Registrar's Signature

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of ertificate of	f Health a of Death	and Mental H	ygien Reg. N		8 02781
	D1		1. Decedent's Name (First, Middle, Last	1)				2. Date of	Death		3. Time of Death
	Physici /Medi		Richard Gordo	n Brown	Jr.			Februa		ay Ye . 2008	4.4
	Examir		4a. Facility Name (If not institution, give Transitions Healt			4b. City, Town	n, or Location o	of Death		c. County of C Carroll	
	Funeral Director		170 20 1517	x XM 2□F 80	ge (In yrs. last birthda) Yrs.	/) If Under 1 Ye Months Da			Birth Day, Year 192		Birthplace (State or Foreign Country) Kansas
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation					10d. Inside City Limits
	e Marylan Ba-f ehow	Director	MD Howard		Highland						1 □ Yes 2X□ No
	th with the	ai Dire	10e. Street and Number 6725 Montell Court			10f. Zip Cod 2077				itizen of Wha JSA	t Country?
036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Heelih and Mental Hyglene ortant: if Item 27 is marked other than *naturel; or iteme 23e or 28e-f ehow injury or other treumatic event, it a Medical Exercitian manal be notified at an exercitian transition of the modified at a second control of the second control of the modified at a second control of the modified at a second control of the modified at a second control of the second control of the modified at a second control of the modi	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden! Armed Forces? 1 Tyyes 2 If Yes, Give Year or Dates:	,	. Was Decedent of If Yes, specify O	Cuban, Mexicar	gin? (Specify Yes or h, Puerto Rican, etc.)	No-		American Indian, Vhite, etc. Thite
21215-0036	within 72 ho ene. than *natur ne Medicel.	Completed by	15. Decedenl's Edi (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or	5+) (Giv	edent's Usual Oci e kind of work do DO NOT use ref alyst	ne durina mos	t of working		Kind of Busine	ernment
Maryland 2	12 should be filed within h and Mental Hygiene. 7 is marked other than * Ireumatic event, Ire Ma	To Be Co	17. Father's Name (First, Middle, Last) Richard Gordon Br		dire	11,00		er's Name (First, Midd Nice Lillia			
	Heelth and I sho tem 27 is ma other treums		19a. Informant's Name/Relationship (7) Douglas J. Brown (or or Rural Route Num Columbia, N			te, Zip Code)
Baltimore,	Pages 1 annual of He		20a. Method of Disposition 1 Burial 2 Coremation 3 4 Donation 5 Other (Specify)		20b. Place of Disp cemetery, cri A11 Cour	ematory or other p	olace)	Date 2-2-08		Location - City	or Town, State
Balti	permit. Pages Department of Important: If It eny injury or once.		21. Signature of Funeral Service Licens Guge Haught	00	_ :	22. Name and Ad	dress of Facilit	y Haight Fu kesville,	ınera	1 Home	·
18760,	Physician and /Medical Examiner the private transit the private transit the private transit that the private transit that the private transit	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						Approximate Interval Between Onset and Death			
O. Box 6	the death certifi y the ettending ched for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregna □ Other (specify)				23d. Date of Month	delivery Day Year
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Division	tal or Attencts after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - Al home, farm, s c. (Specify)	reet, factory, offic	08	28f. Location City or T	(Street a	nd Number of te)	r Rural Route Number,
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	Tot Tot Com	Σ	29b. Signature and title of certifier		٨		ense number		29d. D	ate signed (M	onth, Day, Year)
	V		Mum & H	mem	ナ	ı	0055	5926		2/1/08	?
8	, A		30. Name and address of person who co William J. Hamm	erash Ji-	7086		Center O	h wood	b; ne	MO	21797
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	134					

		State of Maryland / Department of Health and Mental 1- State Amend 10a-c, 10e-f, 16a, perFH,g876, 26/19/10-ate of Death	Hygi Re	ene g. No. 2	008	02782
Physic /Med		al Janu	h	Day	Year 2008	3. Time of Death 5:53 a M
Exam	iner	Southern Maryland Hospital Center Clinton		Pr		George's
Funera Directo		5. Social Security Number 727–01–7899 6. Sex 87 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. 12/0	of Birth h. Day 08/1	920	9. Birthr	place (State or Foreign MD
e Maryland a-f show tifted at	ctor	10a. State 10b. County District of 10c. City, Town or Location			1	0d. Inside City Limits 1 X Yes 2 □ No
th with th 23a or 28 ist be no	Funeral Director	10e. Street and Number 3821 Halley Terrace S.E. 10f. Zip Code 20032		g. Citizen of USA		ntry?
ING 21215-0036 be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	or No-		ce - Americack, White,	
Z1Z15-UU36 d within 72 hours af gjene. er than "natural", or , the Medical Exa <u>mi</u>	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) Maintain and Morkor	1	6b. Kind of E		_{dustry} Maintainanc
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Mary Jan IO Id 2 should be file th and Mental Hy I's marked oth traumatic event	2	(unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route N	lumber,	Wkins City or Town	, State, Zip	Code)
ballimore, IMarylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		Modestine Byrd / Daughter 108 Brookside Road, Sparts 20a. Method of Disposition 1 XBurial 2 Cremation 3X Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) M. J. Copper Veterans 02/04/200	2	0c. Location		own, State
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The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner					
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he law requires that the d has been signed by the ge 2 should be detached	þ	art ii. Other significant conditions continuously to death but not resulting in the underlying cause given in Part i.		acco use cor	atribute to the	ne cause of death?
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To th within To th comp	Me	29b. Signature and title of certifier 29c. License number D 40324		Date sign		Day, Year) 7 2008
Si	ate	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TERRY TO DRIE MD 7503 SUCRATIS ROAD, CLIWTON, M.				
Regist		TTO 0 4 2000 Fine Mr Alegarite				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend it mary arter Department of Freath 2886 Mental The item Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dav Alma Regina Becker 08 Januar 27 DRRO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sel cam If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 22, 1907 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 ☐ M 2 😾 F Yrs. Illinois 100 Director 495-32-9687 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Director 1 ☐Yes 2♥ No Harford Belcamp 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1123 Belcamp Garth 21017 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Black, White, etc. 1 → Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify: white 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 <u>candy packer</u> confectionaries Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christian Becker ဥ Margaretha Carolina Reichert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorien at Riverside 1123 Belcamp Garth Belcamp, MD 21017 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4XDonation 5 ☐ Other (Specify) 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Director 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) **Physician** Due to (or s a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hypothyroidin 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) machail no Bel Air Mn 21014 Mrt mon

Registrar

31. Date filed (Month, Day, Year)

FEB 04

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 31, 2008 **Physician** Month 8: 23 PM January Childs Marie A. P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, Year) 11 18 29 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2**X**F Months Days Hours Min. Country, **Director** 223-34-5354 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 1672 Darley Ave U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Z Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify þ 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "ne any injury or other traumatic event the conce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade K-Mart Dietary 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Forrest Harris Signora Garrett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand Nikki Fowlkes-Daughter 1672 Darley Ave Baltimore, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Pk. 1/7/08 Randallstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 E.North Ave Baltimore, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Jelodysplastic Physician LIDSE disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ending physician and use as the burial-transit Obstructive Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the d 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate 2 No 1□ Yes To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 🗆 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury death, 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide after

P.O. Box 68760 To the Hospital o within 24 hours aft To the Funeral Di

altimore, Maryland 21215-0036

certificate be executed Division or Vital Records, Physiclan: or Attending

> State Registrar

29a. Certifier

29b. Signature and title of certified

Vinay

31. Date filed (Month, Day, Year)

Medical

DHMH 17 Rev 1/2001

and manner stated.

Jagadeesha, M.D

32. Registar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Memorial

Union

29d. Date signed (Month. Dav. Year) January 31, 2008

Hospital

		State of Maryland / Department of Health and Maryland / Department of Health / Department of Health / Department of Health / Department / D	Mental Hygie Reg	ene . No. 2008	02785
Phys /Me	ician dical	1. Decedent's Name (First, Middle, Last) Ling, H Ling, H	2. Date of Death Month	Day Year	3. Time of Death
Exan	niner al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Ci	8. Date of Birth (Month, Day, Y	4c. County of Death Integral 9. Birth Cou	olage (State or Foreign
Directo		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		20 Virgi	10d. Inside City Limits
the Maryl 28a-f sho notified a	rector	Mondand Montgomery Silver Spring 10e, Street and Number 10f, Zin Code	10a	. Citizen of What Cou	1 XYes 2 □ No
death with ms 23a or must be	Funeral Director	250/ //usgrove Rd 20904 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	pecity Yes or No-	USA 14. Race - Ameri	
5-UU30 72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	by Fur	1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify:	o Rićan, etc.)	Black, White,	etc.
DEJILITIOFE, INIGITYIEITG ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If then Z7 is anaked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 16	b. Kind of Business/Ir	apply apply and a second
aryiand < 1	To Be C	17. Father's Name (First, Middle, Last)	e (First, Middle, Ma	iden Surname)	
e, Iviar 1 and 2 sho Health and tem 27 is mo		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ru. 19c. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ru. 19c. Informant's Name/Relationship (Type. Print)	Purtons VII	1/c. 1111	20866
Dallumort Dermit. Pages Department of H mportant: If Ite		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Commetter, crematory or other place)	1-08 S	c. Location - City or T	ana
permit. Departr Imports any inji	ouce		mar - curi	14 240/L	Heme
Physicia /Medica Examine	al er	23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as fardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due (or as a consequence of): Sequentially list conditions,	or respiratory arrest	,	Approximate Interval Between Onset and Death
icate be executed physician and sthe burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Sep5/5 Due to (or as a consequence of): C. July 15 Due to (or as a consequence of): C. July 15 Due to (or as a consequence of):			
eath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of deliv Month	ery Day Year
w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobad	cco use contribute to t 2 No 3 Pro	he cause of death?
The law recate has been page 2 sho	Completed		24a. Was an autopsy performe	prior to co	opsy findings available mpletion of cause of 2 ☐ No
hysician this certifial director	To Be	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho		ce 6 ⊡Other (Speci	(y)
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Certification:	27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 4 Work? Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28d. Describe how		of South March
the Hospital or Attending hin 24 hours after death. the Funeral Director: After mpletely filled in by the funer		4 ☐ Homicide determined building, etc. (Specify) 29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	City or Town, S		, and the second
the Hos thin 24 h the Fur mpletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated. 29b. Signature and title of certifier	rred at the time, date	e and place, and due to	o the cause(s)
ر د چه کو و د که کو کو		> 12 2520		01-27-08	Pay, rear)
<i>y</i>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) * Maria Kayaga D'Arbela P.O. Box 9091 Silver Spring 1	MD. 2091	5	
S Regis	State strar	Maria Kayaga D'Arbela P.O. Box 9091 Silver Spring, 31. Date filed (Month, Day, Year) FEB 0 4 2008	2071	<i>-</i>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 429d Per Phy G876 2/04408...Ih

			1- For amend #29	d Per Phy G8	76 2/04 2 0	rtificate of	lealth and Death	Mental Hy	/giene Reg. No. 2	000	0270
						2. Date of D		Voor	3. Time of Death		
	/Medi			NHBACKE	=12			JAN	3i	2008	MA01-8
	Examin	ner	4a. Facility Name (If not institution,				Location of Deat			ty of Death	14200
8-			NORTHWEST 5. Social Security Number		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs				MORE
	Funeral Director		213-10-5722 Usual Residence of Decedent	1 X M 2 □ F 8		Months Days	Hours Min.			Cou	place (State or Foreign ntry) Maryland
	yland ow at		10a. State 10b. County	1	Oc. City, Town or Lo	cation					10d. Inside City Limits
	a-fsk	ctor	MD Bal	timore	R	eistersto	wn				1 ☐ Yes 2/☐ No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
	ath w	ral	2 Ivy Bridge			211			US.		
98	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 X Marrie	12. Was Decedent Even Armed Forces? 1 \$\forall Yes 2 \subsetent No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 💢 No	ispanic Origin? (San, Mexican, Puer Specify:	pecify Yes or Note Rican, etc.)	o- 14. Ra Bli Spec	ace - Americ ack, White,	
21215-0036	hours tural" al Exa	d b	3 Widowed 4 Divorced	Year or Dates:						Wr	nite
7	be filed within 72 ho ital Hygiene. id other than "natu event, the Medical	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most of wo	rking	16b. Kind of I	Business/In	dustry
212	oe filed within al Hygiene. I other than ' vent, the Me	E	Elementary/Secondary (0-12)	College (1-4or 5+)		Civil Se	rvice		US Gov	ernme	nt
	be filed tal Hygi d other event, tl	BeC	17. Father's Name (First, Middle, L	ast)			18. Mother's Nar	ne (First, Middle	1		
Maryland	should be ind Mental ind marked or umatic eve	To E	Raymond Crumba	cker			Margu	erite R	idgley		
lar	and and sum		19a. Informant's Name/Relationshi	p (Type. Print)	19b. Mailir	ng Address (Street a	and Number or Ri	ıral Route Numb	ber, City or Towi	n, State, Zip	Code)
	s 1 and 2 f Health Item 27 I		Helen Crumbacke	r Wife		y Bridge		*	·		
Baltimore,	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		20b. Place of Dispo cemetery, crei		i	Date	20c. Location	- City or To	own, State
ij	it, Pa	. 8	4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L	• •	Pipe Cre				New Wi		
Ba	permit, Pages Department of Important; If I any injury or once,	1	Sans	Clim	c E	2. Name and Address Line Fune	ral Home	Rei	stersto		own Road D 21136
Į,		1	23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that caused th nly one cause on each line.	e death. Do not ent	er the mode of dyin	g, such as cardia	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final dise se or condition resulting in death)	a		IOMYS PE					Oriset and Death
1	/Medical Examiner		Due to (or as a consequence of): CHONIL ILIONEY DISEASE								
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V	uted d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events								
0,	be executed sician and burial-transit	Еха	resulting in death) Last	Due to (or as a c	consequence of):						
68760,	tificate be executed g physician and as the burial-transit	edical		d							
			IF FEMALE:								
.O. Box	requires that the death certifi een signed by the attending I nould be detached for use as	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 [4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				ate of delive	ery Day Year
Δ.	that the by detact		Part II. Other significant condition	s contributing to death but r	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco use cor	ntribute to t	he cause of death?
Vital Records,	w requires been sign should be	ed by						1 🗆	Yes 2□ No	3 ☐ Prob	pably 4 Unknown
ည္ပ	law as b 2 sl	Completed						24a. Was		. Were auto	ppsy findings available
Ä	The law sate has b	mo						auto perfe 1□ Yes	ormed? 2/2 No	death?	mpletion of cause of 2□ No
/ita	siclan: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Dea				
or/	Physiclan: this certific ral director,	ပ္	1 Yes 2 No	Hospital:	2 ER/Outpatien		4 LI Nursing H	ome 5□Resi	idence 6 □Ot	her (Specif	(y)
Z C	Ing After unel	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	Work		28d. Describe	how injury occu	rred	
isi	Attending r death. ector: After by the funer	icat	2 Accident investiga 3 Suicide 6 Could no	t be	- At home, farm, str		Yes 2 □ No	20f Location /	Ctroot and Misse		- Control Number
Division	al or Attend after death Director: \ d in by the f	Certification:	4 ☐ Homicide determin	building, etc. (Specify)	set, factory, office		City or To	wn, State)	iber or Hura	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b		29a. Certifier (Check only) 1X Certifying 2 Medical E	Physician: To the best of n	ny knowledge, death	occurred at the tin	ne, date and place	, and due to the	cause(s) and m	nanner as s	tated.
	To the H within 24 To the Fi complete	Medical		xaminer: On the basis of ex and manner stated	d.	Т		irred at the time	, date and place	, and due to	o the cause(s)
	Neith Con	2	29b. Signature and title of certifier			29c. License			Jan Jan	1	-
	11		1100				00663	57	Des 1	3 2	800
	101		30. Name and address of person w			Print) いらず れしょ(0201				
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's	Signature	MA I	11+				
	Registr		FFB 0 4 20	108	AT ASSESSED						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 29 January ,2008 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Woodh 8. Date of Birth (Month, Day, Year 6. Sex Age (In yrs. last b If Under Bithplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 💢 F Hours Min Director Carolina Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Baltimore Director 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? eric Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 🕅 No Specify ģ 3 Widowed 4 Divorced Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than ' Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important; if item 27 is marked other the any Injury or other traumatic event, the ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) (HUS band) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 ☐Removal from State Mem Park 2008 4 Donation 5 Dother (Specify) 2. Name and Address of Facility Joseph L. Rus 2222 W. North A 21. Signature of Funeral Service Licensee funeray Balto, Ave. 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ZHEIMER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any and Lin, additionable cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical attending pl IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) a∏lJnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown KIDNEY 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Certification: To 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital c within 24 hours af To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 1) 0054107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IMA BUSINESS CENTER DRIVE REISTERSTOWN 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

0 4

Days

Ellicott City

Ellicott City

21042

Specify:

Hours

1. Decedent's Name (First, Middle, Last) **Physician** Michael George Dana, PHD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2517 Melba Rd. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Sex 1M 2□F 7. Age (In yrs. last birthday) **Funeral** 72 Director 556-44-9705 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ilmportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Director Howard MD 10e Street and Number 10f Zin Code 2517 Melba Rd. Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>Ş</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be Mitchell Dana ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Addr 2517 Me Ellen Dana Spouse 20b. Place of Disposition (a cemetery, crematory) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) **New Cathedr** 22. Name 21. Signature of Funeral Set io Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the r shock, or heart failule. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATI Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 □Ectopi in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other 9 Unknown 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 ☐ Could not be

1 🔲 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

Cri	miologist		US Government						
	18. Mother's Nar	me (First, Middle	, Maiden S	Maiden Surname)					
	Angelina Saladino								
ess (Street	and Number or Ru	ural Route Numb	er, City or	Town, State,	Zip Code)				
lba Rd	. Ellicott Cit	y, MD 2104	2						
Vame of or other pla	ce)	Date	20c. Loc	cation - City or	Town, State				
al Ceme	. la	ın 31, 2008		Baltimo	re, Maryland				
	ess of Facility								
Slack	Funeral Home IId Columbia	P.A.	City M	D 21043					
	ng, such as cardia			D 21010	Approximate Interval Between				
RO	FACT	CALL	cel	7	Onset and Death				
DR	LEAST	CAN	CET	_	5 YEARS				
			2	3d. Date of de	livery				
c pregnanc (specify) _	ey .			Month	Day Year				
(5)550.197_									
g cause gi	ven in Part I.	23e. Did 1	obacco us	se contribute t	o the cause of death?				
		1 🗆	Yes 25	(No 3□ P	Probably 4 ☐Unknown				
		24a. Was	an	24b. Were a	utopsy findings available				
			ormed?	death?	completion of cause of				
	26 Place of Do	1 Yes	2 No	1 ☐ Ye	s 2□No				
DOA Ot	her.	ath <i>(Check only c</i> Home 5 Resi		Dothar (Ca					
28c. Inju	4 □ Nursing F	28d. Describe		☐Other (Spe cocurred	эспу)				
	rk?]Yes 2 □ No								
tory, office		28f. Location (City or To	Street and wn, State)	d Number or F	lural Route Number,				

29d. Date signed (Month, Day, Year)

2:55 PM

Jan 28, 2008

8. Date of Birth (Month, Day, Year)

Sep 2, 1935

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

Howard

U.S.A.

White

14. Bace - American Indian

Black, White, etc.

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2 No

law requires that the death certificate be executed Hospital or Attending Physician: The this certificate

ş

Completed

Be

Certification: To

25. Was case referred to medical examiner?

29b. Signature and title of certific

1 ☐ Yes 2 X No

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

hin 24 hours after death the Funeral Director: Medical 2

State Registrar 2 ER/Outpatient

28e. Place of injury - At home, farm, street, factoriding, etc. (Specify)

28b. Time of

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D16354

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.- U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year James David Dustin January 30 2008 8:45p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Carroll Hospice Dove House Westminster If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ xM 2 □ F 219-56-2672 69 Yrs Director 1939 Jan 25 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Carrol1 Sykesville by Funeral Director 1 ☐ Yes 2 📉 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 525 Klee Mill Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√7 No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) agriculture Elementary/Secondary (0-12) College (1-4or 5+) farm laboror 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William J. Dustin Jr. Ethel Barnes ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Dustin (brother) 453 K1ee Mill Rd., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Emmanuel UMC Cemetery 2-2-08 Scaggsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel erbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (ongestive **Physician** 345 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 ☐ Yes 3 □ DOA 2 ER/Outpatient 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 24 hours after death. e Funeral Director: After 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00059943

DHMH 17 Rev 1/2001

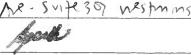
State Registrar 31. Date filed (Month, Day,

Jun (

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

295





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2115)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

FEB 0 4

2008

			For State Registrar	State of Ma	ryland /			nt of H te of L		and M	ental Hy	/giene Reg. No.	2008	02	791
	Dhuaisi		1. Decedent's Name (First, Middle, Last)								2. Date of De		Year	3. Time of	f Death
100	Physici /Medic		Arthur Drumwri				 -				01	26	2008	3:27	P M
	Examir	ner	4a. Facility Name (If not institution, give s	street and number)			4b. City	_	Location o				County of Deatl		
			4022 EDMOND 5. Social Security Number 6. Sex		(In yrs. last		If Unde	>/+ C	If Under				BALTI	MORC place (State	_
Į.	Funeral Director			M 2□F	79	Yrs.	Months		Hours	Min.	8. Date of Bi (Month, Da March 5	ay, Year) 1928	Con	intry) MD	or roreign
6-	Million		Usual Residence of Decedent									,			
	trylan show	_	10a. State 10b. County		10c. City, To	own or Lo		Baltim	oro					10d. Inside C	
	Ba-f s	Director						MIT CITIE							2 □ No
	ould be filed within 72 hours after death with the Maryland Mental Hyglene. arked other than "natural", or items 23a or 28a-f show artic event, the Medical Examiner must be notified at		10e. Street and Number 4022 Edmondson	Avenue			10f. Z	p Code	21229			10g. Citiz	zen of What Coi USA	intry?	
	tems	Funeral	11. Maritar States	12. Was Decedent E Armed Forces?		13. \	Nas Deci f Yes, sp	edent of Hi	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	0-	 Race - Amer Black, White 		
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1xxYes 2 □ N If Yes, Give	0		1 □ Yes	2 XX No	Specify:				African A	_	
0	hour tural	pa pa	15. Decedent's Educ	Year or Dates:	1 10	6a. Deced	tent's Us	ual Occupa	ation			16h Kir	nd of Business/I	ndustry	
7.	in 72 n "na Aedic	plet	(Specify only highest grade	completed)		(Give	kind of w		lurina most	t of workin	ng	100.11	id or basinessii	ildustry	
212	d with glene ir that	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	+)	1abo	orer					Beth	lehem Ste	el	
פ	al Hy l othe vent,	Be	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle		Surname)		
<u> a</u>	Ment Ment arked	To	Ross Drumwrig	ght 							Ella '	White			
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	3	19a. Informant's Name/Relationship (Typ Dorethea Lee / Niece	oe. Print)	1						More, M		Town, State, Z 29	ip Code)	
ore,	of He of He rother		20a. Method of Disposition	amayal from Chata		etery, crer	natory or	other plac			ate	20c. Loc	cation - City or	own, State	
Ĕ	Pag ment ant: h ury o		1 X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (<i>Specify</i>)	emovai irom State	Garris				:				Mills, N	aryland	
Balt	epart nport ny inj		21. Signature of Funeral Service License	e		22	. Name a	nd Addres	s of Facility	y Wy1i	le Funer	al Hom	e, P.A.		
	₹□ = # 9		1/2			6:	38 No	th Gi	lmor S	treet:	: Baltim	ore, M	D 21217		
		١.	23a Part1. Enter the disease, or compli- shock, or heart failure. List only on	e cause on each line	₽.						_	arrest,		Approximat Interval Bet Onset and	ween
)	Physician /Medical	0	Immediate Cause (Final disease or condition resulting in death)	•	EBRO		CVL	AR	Acci	DEN	7				
	Examiner			Due to (or as a	consequenc	ce of):									
4.	\$	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	. Due to (or as a	consequence	ce of):								· · · · · · · · · · · · · · · · · · ·	
	o d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events												
o,	e exectant and an and an and and and and and and a		resulting in death) Last	Due to (or as a	consequenc	ce of):									
8760	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	€ d												
Ö ×	ertific ling p e as 1	Mec	IF FEMALE:												
Vital Records, P.O. Box	death certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome p 1□Live birth	2 ☐ Fetal dea			oregnancy				2	3d. Date of deli		Year
o O	at the de by the a tached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	time of death	1 5∟	Other (s	pecity)						,	
٦.	that the ed by detac		Part II. Other significant conditions con	tributing to death but	t not resulting	j in the ur	nderlying	cause give	n in Part I.		23e. Did	tobacco us	se contribute to	the cause of c	death?
rds	tw requires that been signed to should be deta	d by	PROSTATE	CANCE	2						1 🗆	Yes 2	No 3□ Pro	bably 4 🖼	nknown
<u>ဂ</u>	s beel	Completed									24a. Was	an	24b. Were au	opsy findings	available
Ĭ	sician: The law certificate has birector, page 2 s	mo			_							ormed?/	prior to c death?	ompletion of c 2□ No	ause of
		Be C	25. Was case referred to medical						26. Place	of Death	1 Yes (Check only	2 ☐ No one)	1 □ Yes	ZLI (NO	
>	nysical iis cel direc	To B	examiner? 1 ☐ Yes 2 ☐ Ho	ospital: 1 ☐ Inpatien	nt 2 ER/	Outpatien	t 3 🗆 D	OA Othe				-	☐Other (Spec	ify)	
0	ng Ph tter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury		. Time of Injury		28c. Injury Work			8d. Describe				
<u>0</u>	endii eath. or: A the fu	atic	2 ☐ Accident investigation				M	1 🗆 \	/es 2□N	No					
Division or	al or Attend s after death al Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injur building, etc.	ry - At home, (Specify)	farm, stre	eet, facto	ry, office		2		(Street and wn, State)	i Number or Ru	ral Floute Nun	nber,
	To the Hospital or Attending Physician: whith 24 hours after deals. To the Funeral Director: After this certification in the funeral director, it is a completely filled in by the funeral director, it is a completely filled in by the funeral director, it is a completely filled in by the funeral director, it is a completely filled in by the funeral director, it is a completely filled in by the funeral director, it is a completely filled in by the funeral director, it is a completely filled in by the funeral director.	edical (29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examir	ician: To the best of her: On the basis of end manner stat	examination	lge, death and/or inv	occurre vestigatio	d at the tim n, in my op	ne, date an pinion, dea	d place, a	and due to the ed at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
	To the within To the Comp	Me	29b. Signature and wife of cortifier				29	c. License	number			29d. Date	e signed (Month	, Day, Year)	
					u.p.			DS.	172	2		JAN	VARY 3	1 200	8
0	27		30. Name and address of person who con LEONAW Quett A WS (mpleted cause of dea	ath (Item 23a	a) (Type, I	Print)	E RO	AD#	300					
۳	* Sta		31. Date filed (Month, Day, Year)	02	r's Signature		Carl	B				-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Mary Eberle January 30, 2008 6:15AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Manor Health Care Center Cecil Rising Sun 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months 1 ☐ M 2 🗓 F Davs Hours 213-74-4136 101 Oct. 17, 1906 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 21 No MD Baltimore Reisterstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 W. Chestnut Hill Lane Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Miller ဂ Margaret Slitzer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Granddaughter Lynn M. Hechmer 11221 Woodrush Court, San Diego, CA 92128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 2/2/08 Pikesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road am Eline Funeral Home Reisterstown, MD 21136 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeriate Cause (Final dises se or condition resulting in death) Meumonia useeh Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Alzheimer 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an was and autopsy performed?
Yes 2 2 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 2€ No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Examiner certificate be executed and burial-trar Division or Vital Records, P.O. Box 68760, attending physician for use as the buria the signed by t has page 2 certificate the Hospital or Attending

Examine Physician/Medical ò Completed Be 은 Certification: After the Funeral Director: npletely filled in by the

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

within 72 hours after

I Hygiene.

12 should be filed w h and Mental Hygier 7 is marked other th

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other traumatic event, the once.

Physician

/Medical

Baltimore, Maryland 21215-0036

27. Manner of Death 1 Katural 2 Accident 3 ☐ Suicide

NEIL E. LATTIN

31. Date filed (Month, Day, Year) FEB 0 4 2008

State Registrar

hours

To the Ho within 24 I

0

28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation Injury 1 Tyes 2 □ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier No Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10058354

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O.M

Way, Rising 101 COLONIAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		artment of F			giene Reg. No. 200	8 02793
(K			Decedent's Name (First, Middle, Last,)				2. Date of De Month	ath	3. Time of Death
8	Physici /Medio		David E.	Edwar d s				017	27/ 2008	7:00 A ^M
	Examin	er.	4a. Facility Name (If not institution, give	· ·		4b. City, Town, or			4c. County of D	
سائنو	Funeral		Holy Cross Hosp 5. Social Security Number 6. Secur		ast birthday)	Silv If Under 1 Year	er Spr:	9 Date of Bird	Montgo	Birthplace (State or Foreign
2.0	Director		245-58-4355	M 2□F 66	Yrs.	Months Days	Hours Min.	09/10	y, rear)	Country)
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Maryli f sho	tor	DC			hington	1			1 ⊠Yes 2 No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	23a c ust be	ralD	3222 10th Place	SE		2003	2		U.S.	Α.
336	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ※Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 \(\text{Yes} \) 2 \(\text{M} \) No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2X No		Specify Yes or No rto Rican, etc.)	Black, W	merican Indian, hite, etc. Black
2	72 hou natura lical E	Completed	15. Decedent's Edu (Specify only highest grad			lent's Usual Occup		orkina	16b. Kind of Busine	ss/Industry
2	vithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired	d)	, ming	"	
מ	filed v Hygie ther t		1 2 17. Father's Name (<i>First, Middle, Last</i>)		X-Ra	y Techn		me (First, Middle,	Privat Maiden Surname)	e
an	should be and Mental s marked o	To Be	, , , , , , , , , , , , , , , , , , , ,	Taylor			Jewel		ards	
Maryland 21215-0036	2 should be filed v n and Mental Hygie is marked other t raumatic event, th	-	19a. Informant's Name/Relationship (Ty		19b. Mailir	g Address (Street	and Number or R	ural Route Numb	er, City or Town, Stat	e, Zip Code)
≥	and and m 27 m 27 her tr		Stephanie Kerne				n Loop		,MD 2070	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	emetery, crer	sition (Name of matory or other place		Date	20c. Location - City	
	nit. Pa artme ortant injury	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens			Cemeter Name and Addre	y ∪∠/∪ ss of Facili RO I	01/08 nald Ta	Snow Hil vlor II	I, NC Funeral Hm.
ñ	Dep Imp		*KonoOd	me VII	- J.			52495.000	timore,M	
I.	4 +		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death ne cause on each line.	n. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Metastic	Prost	ate Can	cer			Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):					
	· \$1.50	Jer	Sequentially list conditions, if any, leading to immediate	b Due to (or as a consequ	ence of):					
	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c					244.5	
60,	sate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as a consequ	ience of):					
98/80	physicate by the k	dical		t.						
O. Box	The law requires that the death certific tle has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	/		23d. Date of Month	delivery Day Year
ב	uires that the de signed by the a Id be detached i		Part II. Other significant conditions co	ntributing to death but not resu	ılting in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribut	e to the cause of death?
g	quires in sigr uld be	d by						10	Yes 2 No 3 □	Probably XXUnknown
Records ,	law requir as been si 2 should	Completed						24a. Was	an 24b. Were	autopsy findings available to completion of cause of
		Com						perfo	ormed? deati	n?
VItal	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath (Check only o	one)	
ō	Physral dir	<u>۲</u>	1 ☐ Yes 2 No	I M Inpatient 2 □ E	ER/Outpatien 28b. Time of		4 LI Nursing		dence 6 Other (5	Specify)
0	nding F th. :: After : funera	ition	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2∐No		,,	
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After sompletely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (r Rural Route Number,
	pital c		29a, Certifier 1 Certifying Phy	sician: To the best of my know	wlodge doath	occurred at the ti	mo data and plac	and due to the	equec(s) and manno	r on stated
	e Hos 24 hc e Fun letely	Medical	(Check only one)	iner: On the basis of examinat and manner stated.	tion and/or in	vestigation, in my o	opinion, death occ	curred at the time,	date and place, and	due to the cause(s)
	To the Hospital or within 24 hours af To the Funeral D completely filled in	Me	29b. Signature and title of certifier	0		29c. Licens	e number		29d. Date signed (M	
)	1		1 Gareni	Xultan		D5	6691		01/27/2	800
3	7		30. Name and address of person who co							
Ý)	t o	Ghousia Sultana 31. Date filed (Month, Day, Year)	1500 Fores	st Glo	en Road	. Silve	r Sprin	ng,MD 200	910
	Sta Registr			32. Registrar's Signat	A. A					

			For State Registrar	State of Ma	aryland / Depa	artment of rtificate of	Health and M Death	lental Hy	/giene	2008	0279
	Physici /Medic		1. Decedent's Name (First, Middle, Last Lillie Beatrice					2. Date of Dominion Month Janua	Day	6,2008	3. Time of Death 5:00 PM
	Examin		4a. Facility Name (If not institution, give Hopkins Bayview			4b. City, Town,	or Location of Death			ounty of Death	
	Funeral Director		5. Social Security Number 6. Se		65 Yrs.		If Under 24 Hrs.	8. Date of Bi (Month, D Jan . 2	rth ay, Year) 25,19	9 Birthn	olace (State or Foreign otry) yland
J. 64	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	acation					0d. Inside City Limits
	e Maryla 3a-f sho v tifled at	ctor	MD 10b. County N/A		,	Baltimo	ce				1X Yes 2 □ No
	vith th	Dire	10e. Street and Number	- 7	1 D	10f. Zip Code	11206		10g. Citize	n of What Coun	itry?
	eath v	eral	4406 Bowleys La	12. Was Decedent E			21206	oifu Von or N	0. 14	USA I. Race - Americ	an Indian
920	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	4o	if Yes, specify Cu	Hispanic Origin? (Spe ban, Mexican, Puerto Specify:	Rican, etc.)		Black, White,	
21215-0036	thin 72 ho e. an "natuı Medical	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5	(Give	dent's Usual Occu kind of work done DO NOT use retire	ipation e during most of worki ed)	ng	16b. Kind	of Business/Ind	dustry
	ed wil	Con	12th Grade		R	egister	ced Nurse			rivate	Duty
Maryland	should be filed with and Mental Hygiene, is marked other thar aumatic event, the M	To Be	17. Father's Name (First, Middle, Last) Bess Wilkerson				18. Mother's Name Mary Lo			urname)	
	1 and 2 sho Health and em 27 is ma		19a. Informant's Name/Relationship (7) Earl Wilkerson/		6303	Monika	t and Number or Rura a Place #				
Baltimore,			20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ f 4 □ Donation 5 □ Other (Specify,		20b. Place of Disponsion Commetery, creed Mt. Zic	osition (Name of matory or other pl n Cemet	ery 2/1/	08 °		ation - City or To sdowne	
Balt	permit. Page Department of Important: If any Injury or once,		21. Signature of Funeral Service Licens	ee _			ess of Facility Cha air Rd.				
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ne cause on each lir a. Card	the death. Do not en le. LOVAS aud a consequence of): NOVAS aud a consequence of:		ing, such as cardiac constructions of the such that the su		arrest,	5	Approximate Interval Between Onset and Death Several Years
8760,	ate be executed hysician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):						
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnan □ Other (specify)	су		23	d. Date of delive	ery Day Year
Δ.	juires that the de n signed by the a lid be detached I	۵	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in the u	nderlying cause g	iven in Part I.				ne cause of death? eably 4 ∐Unknown
Vital Records,		Completed						24a. Was auto peri 1 Yes	opsy formed?	24b. Were auto prior to co death? 1 ∐Yes	ppsy findings available mpletion of cause of 2 No
ita	ilcian; Th certificate ector, pag	Be	25. Was case referred to medical examiner?				26. Place of Death				
or V	hyslc his ca Il dire	2	1 Yes 2 No	Hospital: 1 ☐ Inpatie		IL 3 DOA	ther: 4 \sum Nursing Ho	me 5 🗆 Res	sidence 6	Other (Specif	y)
Division 0	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; pompletely filled in the funeral director; possible the f	Certification:	27. Manner of Death 1	28a. Date of Inju (Month, Day 28e. Place of inju building, etc	Year) Injury	M 1 []Yes 2□No				al Route Number,
_	Hospital 24 hours Funeral stely filled	Medical Ce	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	sician: To the best of the basis of and manner sta	of my knowledge, deat examination and/or in	h occurred at the evestigation, in my	time, date and place, opinion, death occurr	and due to the red at the time	e cause(s) a e, date and p	and manner as solace, and due to	stated. o the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier			29c. Licer	ise number		29d. Date	signed (Month,	Day, Year)

29d. Date signed (Month, Day, Year)

ed cause of death (Item 23a) (Type, Print) 30. Name and address of person v

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death Day 31 **Physician** 9:30 PM mazier 2008 Mildred lanuan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Johns Hopkins Bayrian Medical Center Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days Min. Year) 3 8862 220-0 1 M 2 F 9 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or lines 20 marked other than "natural" or lines 20 marked other than "natural" or lines 20 marked other than "natural". 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Amor da 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SH 1222 Funeral 2. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ပ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State -1-08 Crematory 4 □ Donation 5 □ Other (Specify) undalk 22. Name and Address or Facility 21. Signature of Funeral S - ASKTON Rd 2122 DrIAGO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. proximate Interval Between Onset and Death Immediate Cause (Final **Physician** pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner homsis nonar Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 19 months?
1 Yes 2 No
9 Unknown Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by the Id be detach€ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autops 2 □ No 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: Inpatient 1 🗌 Yes 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this Date of Injury (Month, Day Year) 27. Martin of Death 28a. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury Natural 5 Pending investigation 1 Yes 2 □ No death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D0057658 31,2008 of person who completed cause of death (Item 23a) (Type, Print)
Reynalds, MD 4940 Fas 30. Name and address of 5. Baltmore 21224 Stasia Eastern Avenue MD 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 24, Month 2 0 0 8 11:50AM January Ε. Wanda Farmer 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 ☐ M 2 ☐ XF Yrs 48 579-88-0630 30,1959 Washington Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Silver Spring X Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country #202 20902 USA 2015 Randolph Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2XNo Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Relations Pvt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Garrison Hawkins Warren 5 % Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rockville, MD 20850 19a. Informant's Name/Relationship (Type. Print) Calvin Farmer/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Riverdale Crematory 1/30/08 Riverdale, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee 3821 14th Street, NW, Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 34 NinnocoGR Due to (or as a consequence of) STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner certificate be executed

Physician

/Medical

10a. State

MD

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified is

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran

Records, P.O. Box 68760

Vital

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Division

1/24/0

FARMER, WANDA

Physician/Medical Be Completed Certification: To To the Hospital or Attending Pl within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral Medical

		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Tes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 ☐ Residence 6 ☐ Other (Specify)
27. Manney of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work?	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 CertifyIng Ph	ysician: To the best of my knowledge, death occurred at the time, date and place, an inner: On the basis of examination and/or investigation, in my opinion, death occurre	nd due to the cause(s) and manner as stated. In at the time, date and place, and due to the cause(s)

29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

HUSPIM

29d. Date signed (Month, Day, Year)

NO 00052774

10/010 (31. Date filed (Month, Day,



ow

and manner stated.



SUBUNBAN

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar amend #201	per FH G876 2/13/	thicate of Death	ientai Hygie _{Reg.}	ne №.2008	02797
ę	Physici	an	1. Decedent's Name (First, Middle, Last)	V =0.00		2. Date of Death Month JANuary	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death	JANUARY .	29 ZeO8 4c. County of Death	4.40 AM
		•	Sinai Hospital of	Baltimore	Baltimore City		NA	
artic	Funeral Director		5. Social Security Number 6. Sex 10	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo	9. Birthpl Count 926 West	ace (State or Foreign ry) Virainia
	land bw tt		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation		10	Od. Inside City Limits
	e Mary a-f sho lified a	ctor	Md. N/A	Balt	imore-			1 XÎYes 2 □ No
	with the	Director	10e. Street and Number	1	10f. Zip Code	10g.	Citizen of What Count	ry?
	death ms 23 r must	Funeral	3 LO 1 C 1 T 1	2. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Sp. f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - America	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No	r Yes, specify Cuban, Mexican, Puerto I □ Yes 2 [2]No <i>Sp</i> ec <i>ify:</i>	Rican, etc.)	Specify: P(itc.
Maryland 21215-0036	72 hou 'natura dical E	eted	15. Decedent's Educ (Specify only highest grade	ation 16a. Deced	lent's Usual Occupation kind of work done during most of work OO NOT use retired)	16i	o. Kind of Business/Ind	ustry
121	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	OO NOT use retired)		Short of	Transportation
nd 2	al Hygi l other vent, t	Be C	17. Father's Name (First, Middle, Last)	71	18. Mother's Name	(First, Middle, Mai		Transportation
yla	should to nd Ment marked umatic e	힏	John Gill	am	Bess	sie M	ayfield	
	1 and 2 sho Health and tem 27 is ma	Ĭ	19a. Informant's Name/Relationship (Type	e. Print) (SISTER) 19b. Mailing	g Address (Street and Number or Run) 7	Ave "R	ity of Town, State, Zip	21216
Baltimore,	Pages 1 and of Heamint: If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. Place of Disposemoval from State		Pate 200	c. Location - City or Tov	vn, State
Ħ	artmeni artmeni ortant: injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Arbatus	Name and Address of Facility	2008 F	Salto, M	d
Ba —	permi Depa Impo any is	d d	Doseph a	L. Buss 2	Seph L. Russ	Euneral e. Balto.	Home P.A	6
ı				cations that caused the death. Do not ente e cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due tl (or as a consequence of):				6 days
ė	Examiner		Sequentially list conditions b.					
13=	rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease of Injury that initiated events	Due to (or as a consequence of):				
oʻ	an and rial-tra	Exal	that initiated events resulting in death) Last	Due to (or as a consequence of):				
68760	tificate be executed g physician and as the burial-transit	edical	d					
Box	± 5, 6		PREMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of deliver	ry
о. О.	The law requires that the death cer the has been signed by the attendir age 2 should be detached for use	Physician/N	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Other (specify)	<u> </u>	Month	Day Year
Д.	n requires that the deben signed by the should be detached	by Ph		tributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of death?
ords	equires	ted b				1 ☐ Yes	2 No 3 Proba	ably 4 □Unknown
Records,	The law rate has be page 2 sh	Completed				24a. Was an autopsy performed	24b. Were autor prior to com death?	osy findings available appletion of cause of
VII		Be Co	25. Was case referred to medical		26. Place of Death	1 Yes 2 (Check only one)	No 1 ☐ Yes	214No
	Physic this ce al direc	일	1 163 2 410	ospital: 1 Inpatient 2 ER/Outpatient			e 6 □Other (Specify)
00	th. : After s funera	tion:	27. Mann of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	njury occurred	
DIVISION OF	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,
	spital nours a neral [29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, death	occurred at the time, date and place,	and due to the caus	e(s) and manner as sta	ated.
	the Ho hin 24 I the Fu	Medical	one) 2 Medical Examin	er: On the basis of examination and/or inv and manner stated.	estigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
1	wit 70	2	29b. Signature and title of certifier	Since un	29c. License number RES - 000		Date signed (Month, I	
,		-	30. Name and address of person who cor	npleted cause of death (Item 23a) (Type, F		JA	Nuary 29,	2008
			Nicole L Strond,	MD Sinai Hospital	of Baltimore			
	Sta Registr		31. Date filed (Month, Day, Year) FFR 0 4 2008	32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 02798 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 9:55 AM ORDONK. 2008 DRIMES FEBRUARY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner LTIMORE OSPITAL If Under 1 Year | If Under 24 Hrs.

Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) 11/10/1927 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 219-20-7636 Months 1XM 2□F 80 Yrs MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore City 1 XYes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 1443 Richardson Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 № Yes 2 □ No
If Yes, Give
Year or Dates: Coast Quard Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify: White <u>ک</u> 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Longshoreman Shipping 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) Be Vernon Grimes Sr. Daisy Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gordon Grimes Jr. / Son 1443 Richardson Street, Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2/6/2008 Glen Haven Memorial Park Glen Haven MD Signature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility
Charles L. Stevens Funeral HomeInc. 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-t ansit that initiated events resulting in death) Last requires that the death certificate be exer Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical the as attending IF FEMALE: detached for use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>د</u> 2 No 3 Probably 4 Whiknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D23130 30. Name and address of permin who completed cause of death (Item 23a) (Type, Print) 3001 S. Hander St. MD 2 1225 JE SHOK TEN 31. Date filed (Month, Day, Year) 2. Registrar's Signature State FEB 0 4 2008 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Giardina Grie /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Charlestown Health Center Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. Nov 9, 1911 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 20 F 96 Director 212-50-3606 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Catonsville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 707 Maiden Choice Lane #3202 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home housewife 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any liqury or other treumatic event 2008. Mary Anna Koslowski Joseph Luczkowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6810 Dina Leight Court Springfield, VA 22153 19a. Informant's Name/Relationship (Type, Print) 6810 Dina Leight Court Springfield, VA Joseph A. Giardina/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee de Nade State Attatomy Bard 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. Just only one cause on each line. Onset and Death Immediate Quee (Final disease or condition **Physician** Me tastatic resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificete be executed ettending physicien and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy tor: After this certificate hes been signed by the ette the funeral director, page 2 should be detached for Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě 1 Yes 2 No 3 Probably 4 Drinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 9 Residence 6 Other (Specify) ဥ 1 Yes 2 € No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deneen Maiden Catonsy//e mp 2/228 Bowlin 711 Choice Lane mn 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 04 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #31 Per DVR G8/6 2/04/08 JH etrar DVR G8/6 2/04/08 JH Reg. No. Reg. No ZUU8 028001. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 26 JÄNUARY C GREENBERG 2008 3:10P M ALLEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL DOVE HOUSE WESTMINSTER 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 12/26/1925 Months Days Hours Min 82 MD 219-22-3625 Director Usual Residence of Decedent r 28a-f show notified at 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits 1 □Yes 2 No Director MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. Is marked other than "natural", or items 23a or and an and a saminer must be reaminer must be reaminer must be reaminer must be reaminer. 750 CROWS COURT, APT. #3-B USA 21158 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No WWII If Yes, Give Year or Dates: KORE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: ģ Specify: 3 Widowed 4 Divorced KOREA Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FOREIGN LANGUAGE US NAVY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GREENBERG ROSE FISHER **GEORGE** ဥ or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 Is
any injury or other trau VIVIAN SHAPIRO / SISTER 45 WASHINGTON ROAD, WESTMINSTER, MD 20a. Method of Disposition
1 🗖 Burial 24 □ Cremation 3 □ Removal from 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MD VETERAN CEMETERY 02/01/2008 OWINGS MILLS, MD 4 🗆 D 5 Other (Specify uneral ervice Lic 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner certificate be executed burial-transi that initiated events and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. physician s the buria Physician/Medical nding pase as t IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) the been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy perform 22 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 3□ DOA P 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Deatl 28d. Describe how injury occurred After 1 To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural Injury 1 TYes 2 □ No investigation 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check or one) 29b. Signatur nd title of certifier 29c. License number 29d. Date signed (Month. Day, Year ntv. Street Westningter, mo (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State Registrar	State of Maryland / De	epartment of He Certificate of De	eath	Reg.		02801
1	nysicia Medic xamin	in al er	Decedent's Name (First, Middle, Last) Edna Haa. Facility Name (If not institution, give since the salth of th		4b. City, Town, or Lo	Jaccation of Death	nuary	Day Year 22,2008 4c. County of Death	3. Time of Death 3:00A M
Dire	neral ector		5. Social Security Number 6. Sex 220-22-4951	M 2 PF 7. Age (In yrs. last birthd	Months Davs	f Under 24 Hrs. 8 Hours Min. F	Date of Birth (Month, Day, Yeeb. 3,	9. Birth Co. L928 Bal	place (State or Foreign intry) timore
e Marylan	tiffed at	Director	MD Baltimor	re Ran	ndallstown				10d. Inside City Limits 1 X Yes 2 □ No
with th	at be no		10e. Street and Number 3710 Sonora Raod	1	10f. Zip Code 2113	3	Tog.	Citizen of What Cou	intry ?
72 hours after death with the Maryland	the Medical Examiner must be notified at				13. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 X No	anic Origin? (Speci Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
<u>c</u>	Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Completed) (G liii	ecedent's Usual Occupation Give kind of work done during the control of the cont	on ing most of working	160	b. Kind of Business/l	•
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and M	amat	은	Carroll Chanes 19a. Informant's Name/Relationship (Typ. Lawrence T. Hars	pe. Print) 19b. M	Mailing Address (Street and 59 Lockwook Limore, M	d Number or Rural I		ity or Town, State, Z	iip Code)
Pages 1 and 2	- b	112	20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b. Place of Di cemetery,	isposition (Name of crematory or other place) Universit	Da		shingto	
Department of h	any injury		21. Signature of Funeral Service License	•	22. Name and Address 3821 14th	of Facility Aus	tin Roy		
ate be executed XX	dical niner per per per per per per per per per p	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of) CONGESTIVE Due to (or as a consequence of) HYPERTENS Due to (or as a consequence of)	C COLO. HEART	R CAI FAILU	XCER RÉ		Onset and Death
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Jing Phys	Atter this certificate funeral director, pag	ion: To Be	27. Manner of Death 1 Natural 5 Pending	ospital: 1 Inpatient 2 ER/Outp. 28a. Date of Injury (Month, Day Year) 28b. Tin	atient 3 DOA Others ne of 28c. Injury a work?	4 Privursing nom		e 6 Other (Speinjury occurred	cify)
ai or Attending s after death.	to the Funeral Director: Affer in completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)			Bf. Location (Stree City or Town,	et and Number or Ru State)	ural Route Number,
To the Hospital or A within 24 hours after	ne Funero	Medical ((Check only 2 Medical Examinone)	initian: To the best of my knowledge ther: On the basis of examination and/and manner stated.	or investigation, in my opin	nion, death occurre	d at the time, date	and place, and due	to the cause(s)
Tot	moo Com	Σ	29b. Signature and title of certifier Savindal	LeTulk M	29c. License i			Date signed (Mont)	
1	Sta	to.	30. Name and address of person who co	mpleted cause of death (Item 23a) (Ty MAY 38 Registrar's Signature	ype, Print) 1(e)-Plan	ce Du	ndall	MD.	E 2 1222

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		for State	State of Mary		epartment of F Certificate of I		, ,	2001	0 0000
		Registrar 1. Decedent's Name (First, Middle, Las	st)		Jertincate of	Dealli	2. Date of Dea	teg. No. 🛆 🔰 🗓 i	3. Time of Death
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Funeral	7	5. Social Security Number 6. S.		n yrs. last birth		timore If Under 24 Hrs.	8. Date of Birth	9. Bi	rthplace (State or Foreign
Director		217-24-2704 ¹ Usual Residence of Decedent	XIM 2□F 8		rs. Months Days	Hours Min.	(Month, Day Sept. 2	Year) C	MD
yland low		10a. State 10b. County	10	Oc. City, Town	or Location				10d. Inside City Limits
a-f sh	ctor	MD Baltimor	re (Owings	Mills				1 □Yes 2 ☑ No
or 28 be no	Director	10e. Street and Number		_	10f. Zip Code		1	0g. Citizen of What C	ountry?
sath v is 23a nust	eral	11940 Park Height	s Avenue	ria II S	21117			U.S.A. 14. Race - Am	origen Indian
fter de r Item Iner r	Funeral	11. Marital Status 1 ☐ Never Married 2☐ Married	Armed Forces? 1 ☐ Yes 2 📉 No	erin u.s.	13. Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Wh	
permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 19		1 ☐ Yes 2 █ No	Specify:		Specify: W	
in 72 t	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. E	Decedent's Usual Occup Give kind of work done of life. DO NOT use retired	ation during most of work d)	ing	16b. Kind of Business	s/Industry
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Meni Meni Marker Marker	P	John E. Hale				Lillie N			
d2sh thanc ?7 is n traun		19a. Informant's Name/Relationship (7			Mailing Address (Street				
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permit. Departri Importa any Inju		21. Signature of Funeral Service Licen	see,		22. Name and Addres	ss of Facility	11824	Reistersto	wn Road
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		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the one cause on each line.		Ť				Approximate Interval Between Onset and Death
Physician // // // // // // // // // // // // //		Immediate Cause (Final disease or condition resulting in death)	a. Coro	nic ol	structive F	ulmonar	1 duse	are.	unknown.
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al or A	Certification:	4 ☐ Homicide determined	building, etc. (5		n, street, factory, office		28f. Location (Si City or Towi	treet and Number or F n, State)	Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical (29a. Certifier (Check only one) Check only 2 Medical Exam	ysician: To the best of m niner: On the basis of exa and manner stated	amination and/	death occurred at the tin or investigation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, c	ause(s) and manner a date and place, and du	as stated. ue to the cause(s)
To t Withi To tl	Ň	29b. Signature and title of certifier	1 Mn		29c. License			9d. Date signed (Mor	
11		Kapil Garge		// 62 \ =		-000.		Febrary 1	_ 2008 .
15		30. Name and address of perso who capil-Gangw	a. M.D.	Sinai-	Hospital	or Ba	lumore	0	
Sta Registr		31. Date filed (Month, Day, Year) FFB (1.4. 2008)	32. Registrar's	Signature	sall)				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 rer FH G876 2.7 L1708 JH

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3/1/ 11:04 AM HARRIS JR. 31 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 215-12-1967 6. Sex HOSOITAL WORL 7. Age (In yrs, last birthday) Yrs. If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign Months 1**X**M 2□ F Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Maryland 30 Himore NIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 United MENU a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) abover 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, annie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) Bultimere Maryland 21218 1108 Darley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1' Burial 2 □ Cremation 3 □ Removal from State Battimore Camatery Leb. 6,200 4 Donation 5 Dother (Specify) 270 Fredhi Han Pass 21. Signature of Funeral Service Licensee L. Mythemit 2/229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SHOCK SEPTIC Due to (or as a consequence of): PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: within 2

Physician

/Medical

Examiner

10a. State

Completed by Funeral Director

To Be

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merital Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar and once.

Physician

/Medical

dical		d								
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3⊟Ectopi					23d. Date of d Month	elivery Day	Year
by	Part II. Other significant conditions	contributing to death but not res	sulting in the underlyir	ng caus	e given in Part 1.		23e. Did tobacco u 1 ☐ Yes 2			use of death?
Completed							24a. Was an autopsy performed? 1∐ Yes 2 ☑ No	prior to death?	completion	ndings available on of cause of No
Be (25. Was case referred to medical examiner?				26. Place of De	eath (0	Check only one)			
To	1 Yes 2 No	Hospital: 1 Inpatient 2]ER/Outpatient 3□	DOA	Other: 4 Nursing	Home	5 ☐ Residence	6 □Other (Sp	ecify)	
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	- 1	Injury at Work? 1 □ Yes 2 □ No	280	d. Describe how injur	y occurred		
Certification	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, street, fac fy)	tory, of	fice	281	Location (Street an City or Town, State	d Number or F	Rural Rout	te Number,
Medical (nysician: To the best of my knominer: On the basis of examination and manner stated.								
ME	29h Signature and title of certifier.			29c. Li	cense number		29d Da	te signed (Mo	nth Day	Year)

29c. License number

RES-000

BLUD

29d. Date signed (Month, Day, Year) JAN 31, 2008

21239

BALTIMORE, MD

State Registrar 29b. Signature and title of certifier,

HAKIM 32. gistrar's Signature 31. Date filed (Month, Day, Year) FEB 0 4 2008

5601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



RAVEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 5:15 a 18 2008 Beatrice V. Hall /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Nursing Home Prince Georges Largo If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 1 F 9-19-1914 Director 578-36-4392 93 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10b. Counfy 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 NYes 2 No Directo Md P.G. District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2001 County Rd. 20747 Funeral U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black P Q 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 d 2 should be filed within the and Mental Hygiene.
7 Is marked other than "1 Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Private 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Pearl Tilghman ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any injury or other traun Delorise V.Brooks/Daughter 2001 County Rd.District Heights, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 DBurial 2 □ Cremation 3 □ Removal from State Resurrection Cem. 01/26/08 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Ignature of Funeral Service License 22. Name and Address of FacilityRonald Taylor II Funeral Hm. Trona 108 West North Ave.Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that Queed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR Physician ACCIDENT /Medical Due to (or as a consequence of): **Examiner** HEMORKHAGIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transi Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as use IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ THRIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 70 leted 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Compl page 2 certificate has autopsy performed? 1 Yes 2 2 No Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐No 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Attending (Month, Day Year) To the huser within 24 hours after use...

To the Funeral Director: After a consistent of the funeral plied in by the fur 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

State Registrar

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

29c. License number

D47604

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Bernell Harris 1-26-2008 M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery

9. Birthplace (State or Foreign Country) Spring r | fr Under 24 Hrs. Silver 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Days Hours **X**☐M 2☐F 74 314-26-9481 April 17,1983 Illinois Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No SilverSpring Montgomery Co. 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? 20910 U.S.A. 2001 Spencer Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 ঐYes 2 □ No5 - 29 -If Yes, Give Year or Dates: 1957 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Supervisor Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Judson Harris Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 Spencer Rd. SilverSpring, Md 20910 Mable Harris/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Md. Veterans Ceme. 2-06-2008 Cheltenham, MD 21. Signature of Funeral Service Doensee 22. Name and Address of Facility Ronald Taylor II FuneralHm 108 W. North Ave. Baltimore, Md. 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Renal Failure Due to (or as a consequence of) Polycystic Kidney Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify)

Physician /Medical Examiner Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Md

Funeral

Director

r than "natural", or items 23a or the Medical Examiner must be

s 1 and 2 should be filed w if Health and Mental Hygier Item 27 is marked other th other traumatic event, the

permit. Pages 1 Department of H Important; If itel any injury or otl

if item 2 or other

with the Maryland show

filed within 72 hours after death

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar <u>a</u>

Division or Vital Records, P.O. Box 68760,

Hospital or Attending after death

To the Hospital or within 24 hours at To the Funeral D

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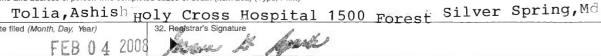
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ed by PI	Part II. Other significant conditions	contributing to death but not resulting in the unc	derlying ca	use given in Part I.			se contribute to the cause of death? No 3 Probably 4 Unknown
Complet						opsy formed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2፟፟ዾ No
Š	25. Was case referred to medical			26. Place of De	ath (Check only	one)	
0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient	3 🗆 DO/	Other: 4 Nursing	Home 5□Re	sidence 6	5 □Other (Specify)
ation:	27. Manner of Death 1 M Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	M 28	3c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	e how injur	y occurred
SETTIC	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		et, factory,	office	28f. Location City or T	(Street and own, State)	d Number or Rural Route Number,)
dical	29a. Certifier 1. ☐ Certifying Pr (Check only one) 2 ☐ Medical Exam	hysician: To the best of my knowledge, death miner: On the basis of examination and/or invented and manner stated.	occurred a estigation,	at the time, date and place in my opinion, death occ	e, and due to the	ne cause(s) e, date and	and manner as stated. I place, and due to the cause(s)
ž	29b. Signature and title of certifier	3	29c.	29c. License number		29d. Date signed (Month, Day, Year)	

State Registrar

31. Date filed (Month, Day, Year)

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



H0064588

1-27-08

20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #8, perFH, g876, 2/25/08 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month 20 **Physician** 2008 DNNIC lanuary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Home If Under 1 Year | If Under 24 Hrs. IHMORE 5. Social Security Number NURSING 8. Date of Birth 2/8/1920 9. Birthplace (State or Foreign (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 154-66-8975 1 M 2 VF Months Days Hours Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ntt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ortant: if item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medica Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? .5 08861 Funeral 14 Bace - American Indian Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Pes 2 No Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) NURSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN KNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is GILEN BURNIE Alvarado BUSKIN Md 6606 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FUYERAI Rd. Approximate Interval Betweer onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 0 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnap 3 Ectopic pregnancy in the past 12 months
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy Director: After this certificate Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

Registrar

State

31. Date filed (Month, Day,

Year)

2008

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** MMA EMILINS ,2008 31 Smucra /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 21 S'DST 21218 STREET BOTTMUNE, MD NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🛛 F Days 217-16-3281 94 12 13 ٧Ã Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene. other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 X es 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g: Citizen of What Country? U.S.A 332 East 21st Street 21218 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3X Widowed 4 ☐ Divorced Black Completed event, the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Garrison Forest College (1-4or 5+) Elementary/Secondary (0-12) House Keeping School 5th Grade NA permit. Pages 1 and 2 should be filt. Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other **** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Footes Emmett Wilkerson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 332 E.21st Street Baltimore, MD 21218 <u>Bertha Jenkins</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/5/08 Randallstown, MD King Mem Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East E.North Ave Baltimore, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arrthymia /Medical Due to (or as a consequence of) Examiner per tem SION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physician and is the burial-transit the death certificate be executed 1) EMENTIA Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. detached 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No MUMMUL 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 No 1 Tes 2 ER/Outpatient 3 DOA ဥ 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 atural Injury 5 | Pending 1 Yes 2 No investigation 2 ☐ Accident To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

within 24

State Registrar one)

29b. Signature and title of certifier

Benjon

2008

2909

of person who completed cause of death (Item 23a) (Type, Print)

HUNT, MO

Registrar's Signature

29c. License number

D25373

DRUID Hill

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year me 08 one /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITA 9. Birthplace (State or Foreign Country) 8. **Funeral** Days Min. Hours 1****\\ M 2□ F Director Georgia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location f show 10d. Inside City Limits th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 MYes 2 □ No Director fimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ₩ Widowed 4 Divorced Blac 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Kestu 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျှ ones enr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Son) Department of Health ar important: If item 27 Is any Injury or other trau Mr.Micha 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 M Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Holiness utler, New Jersey 21. Signature of Funeral Service Licens aito. Mil 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fullure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death **Physician** unse disease or condition resulting in death) /Medical equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to s a consequence of P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown signed by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has b lirector, page 2 s autopsy 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day 5 ☐ Pending investigation 1 🗌 Yes 2 🗌 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records,

State Registrar

31. Date filed (Month, Day, Year) FEB 0 4

29b. Signature and title of certifier

Ulmen

and manner stated.

Memorial

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tettwalle

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 02809 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 29 Mary Jordan 2008 12:04 A^{M} 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harborside Healthcare Harford Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 13, 1959 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 213-88-6181 1 M 2 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Baltimore** 1 2 Yes 2 □ No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 USA 26 Cedar Heights Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status African American 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 HNo Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working unk life. DO NOT use retired) unk Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name *(First, Middle, Maiden Surname)* Gloria Jordan 17. Father's Name (First, Middle, Last) Be Joseph High ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 Cedar Heights Avenue #B; Baltimore, MD 21207 Charles Johnson, 3rd / Uncle 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 Removal from State 01/30/2008 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. Gane 638 N. Gilmor Street; Baltimore, MD 21217 23a. Part1. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exam resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 1☐ Yes Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To

that the death certificate be executed attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760. ed by the a ate has been signed by page 2 should be detact the Hospital or Attending Physician; hin 24 hours after death. after death. the

Funeral

Director

r 28a-f sh notified

be

"natural", or items 23a

traumatic event, the Medical

al Hygiene.

Health Im 27

Physician

/Medical **Examiner**

and 2 should be filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

25. Was case referre		
1 Yes 2 N	0	
Natural 2 Accident	5 Pending investigation	า

(Month, Day Year)	Injury M	Work?	2□No	28d. Describe now injury occurred
8e. Place of injury - At he building, etc. (Special	ome, farm, street, fa	ctory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier	
(Check only	
one)	

3 ☐ Suicide

4 ☐ Homicide

🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b.	Signature	eand t	itle of co	ertifier
	M	d	M	\mathcal{U}
	' '/	-		•

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wyawa Douge 821 N. Eutow

6 Could not be determined

Street, Baltiniae, M2/201

State Registrar

Medical

32. Registrar's Signature ed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Registrar Certificate of Death Reg. No. 2008 028 0
r			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
	Physici /Medic		Richard Leroy Lawrence Feb 3, 2008 Year 12:15 A ^M
	Examin	_	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
6 6 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5			Carroll Hospital Center Westminster Carroll
	Funeral Director		5. Social Security Number 316-36-5558 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Security Number (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Months Days Hours Min. Months Days To 32 10 (2) To 32 (2) (Month, Day, Year)
3	de .		Usual Residence of Decedent
	arylan show	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	he Ma 18a-f otifie	Funeral Director	MD Carroll Taneytown 1 □ Yes ¾CXNo
	a or 2	ă	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4317 Old Taneytown Rd. 21787 United States
	seath ms 23 must	era	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian,
9	after or iter		1 Never Married 2 Married 1 12 Yes 2 No 1939
9	ours ural",	d b	XX Widowed 4 □ Divorced Year or Dates: White
- -	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
77	withi jene. r than the M	шо	Elementary/Secondary (0-12) 12th College (1-4or 5+) Salesman Automobile
פַ	- 0 9	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
<u>a</u>	Menta	10	Russell Lawrence Elnyth Winestock
aitimore, Maryland 21215-0036	s 1 and 2 should be fil of Health and Mental H item 27 is marked oth other traumatic even		19a. Informant's Name/Relationship (Type. Print) Deborah David (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 Navesink Dr. Pennington, NJ 08534
e)	1 and Healt em 2 ther		20a Method of Disposition 20b, Place of Disposition (Name of Date 20c, Location - City or Town, State
jo L			1 Burial 2 Tix remation 3 Removal from State 4 Donation 5 Other (Specify) S. Carroll Crem 2/4/2008 Winfield, MD
alt	permit. Page Department Important: If any injury or once.		21 Signature of Fineral Service Licenser 22. Name and Address of Facility
ñ	Der Jung		Burrier-Queen Funeral Home and Crematory, P.A. 1212 W. Old Liberty Rd. Winfield, M. 21784. 23a. Part, Enter the followed introduction and applying a part of the following a part of the following and applying a part of the following a par
			Shock, of fleat failure. List only one cause of each lige.
	Physician		Immediate Cause (Final disease or condition resulting in death) Onset and Death Onset and Death
	/Medical Examiner		Due to (or as a consequence of): Athere & SCL EROSIS
		ē	Securitary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
	cuted id ansit	Examiner	that initiated events C.
Ö,	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):
8760	ate hy:	dical	d
9 X	leath certific attending p	Physician/Med	IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery
Rox	atten aften I for u	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No
л О	at the de by the a tached t	hysi	9 Unknown 9 Unknown
	w requires that s been signed to should be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Vital Records,	requir sen si nould I	ted	PhAB DO my OLY 515 1 yes 2 No 3 Probably 4 Unknown DISSEMINATED COACOLOPATHY 24a. Was an autopsy findings available prior to completion of cause of
Š	has be	Completed	
ᆱ			1□ Yes 2 No 1 □ Yes 2 No
	'sician: The law s certificate has l lirector, page 2 s	o Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify)
Ö	ding Phys h. After this funeral di	n: To	27. Mapner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
Ö	Attending I death. ctor; After y the funer	atio	2 Accident investigation M 1 Yes 2 No
Division or	or Atta	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)
	pital o		29a. Certifler 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical	C(Check only one) Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To th within To th comp	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	/		D29246 2-3-08
	5	Ì	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	<i></i>	•	31. Date filed (Month, Day, Year) 32. Red Strar's Signature.
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RASPANA, Natuanal 22-1Washinston Hots Westminsten, MW21/5 31. Date filed (Month, Day, Year) See Strar's Signature FEB 0 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #17, per FH, C876, 2/4/08 TTCertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Lee Gerald J01 5:05 AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Baltimore VA Medical Center Baltimore 8. Date of Birth (Month, Day Ye. If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) 1941 **Funeral** Hours Days 1**√**M 2□ F 66 New York 086-30-9960 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No N/A Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #1C 3801 Wabash Avenue #1C USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1961 Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced 1965 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry City of Paterson, Elementary/Secondary (0-12) College (1-4or 5+) Laborer 12th grade | 17. Father's Name (First, Middle, Last) | Washington New Jersey 18. Mother's Name (First, Middle, Maiden Surname, Be Merrell C. Waahington Tona Tiee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 Ethel Lee/ Wife 3801 Wabash Avenue#1C Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Greenmount Cemetery 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State /4/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Survice Licen 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 tarno Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest effects, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Caus Final disease or condition resulting in death) **Physician** 10 years Cardiomyopathu /Medical Due to (or as a nsequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of ifjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No. detached 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy certificate 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this After thi funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NPI 1770786394 Mirkle, M.D. 01-28-2008

State Registrar

DHMH 17 Rev 1/2001

Inomas 31. Date filed (Month, Day, Year) 10 N.

32. Registrar's Signature

Greene Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Merkle M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #8, perFH,g876, 2/4/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year NHOC LANEHART JANUARY 8:50 PM /Medical 28th 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARY LAND MEDICAL CENTER

5. Social Security Number 6. Sey 7. Age (In yrs. last birthday) BALTIMORE NIA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth June 13 Day 1928 **Funeral** 1X M 2□F Months Days Hours Director 212-28-0897 MD Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be 23a 8569 Neptune Dr. Funeral 21122 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 □ No If Yes, Give Year or Dates: "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
7 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Painting Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 Is marked any injury or other traumatic ev ٩ Carl H. Lanehart Nora Schanell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Beatrice V. Lanehart 8569 Neptune Dr. Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Feb 02, 2008 Ellicott City, Maryland Good Shepherd Cemetery 21. Signal re of Funeral pervice Licensee 22. Name and Address of Facility Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043

3871 Old Columbia Pike Ellicott City, MD 21043

3871 Old Columbia Pike Ellicott City, MD 21043

shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BACTEREMIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dus to (or as a consequence of): requires that the death certificate be executed y physician and ts the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) P.0. the 9 Unknown Š signed b d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, CONCIESTIVE HEART FAILURE 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed PULMONARY HYPERTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performe certificate 2 N No this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1XInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

Meena V Shah, MD 31. Date filed (Month, Day, Year) FEB 0 4 2008

29b. Signature and TNe of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Street

29c. License number

Baltimore, MD

29d. Date signed (Month, Day, Year)

28, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Thomas Locklear 1, 2008 4c. County of Death /Medical 0535 February, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner <u> Stella Maris - Dulaney Valley</u> Timonium **Paltimore** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Funeral . Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 XM 2 ☐ F 71 Director <u> 241–50–9005</u> 06/08/1936 North Carolina Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at 1 Yes 2 No Director 28a-f Maryland | Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be items 23a Completed by Funeral 8182 N. Boundary Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 ☐ Never Married 2 X Married altimore, Maryland 21Ź15-0036 "natural", or 1 ☐ Yes 2 No Specify: American Indian 3 ☐ Widowed 4 ☐ Divorced Year or Dates: other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. 4 Assembly Worker <u> Automotive Factory</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) -ERRUARY Be Health and Menta tem 27 is marked ည Clarance Locklear Zebra Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 South Broadway Baltimore, Maryland 21231 <u>Jeanette Walker - Fxecutrix</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 X Burial 2 □ Cremation 3 □ Removal from State 02/05/2008 Red Springs, North Carolina 4 ☐ Donation 5 ☐ Other (Specify) Mount Flam Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Paltimore, YOU Maryland 21231 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.) Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if an cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-tran Due to (or as a consequence of) attending physiciar Physician/Medical nse 9 IF FFMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division or Vital Record 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed es 2 , page certificate 1□ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICS 2 No 1 Tyes 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: the Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) à 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 211108

Registrar

35 AM

MAMMOOU 31. Date filed (Month, Day, Year) 32 egistrar's Signature FEB 0 2003 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 Dulaney Villy RD

Timonium

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

PCSE

LIEBERHAN,

Funeral Director

Baltimore, Maryland 21215-0036 Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, State

Registrar

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Registrar Decedent's Name (First, Middle, La	ast)		er lincale of	Dealli	2. Date of Dea	leg. No. 🛴 🔱	00 0201
ROSE	431)	v	LIEDEDMA	101	Month	Day	Year 3. Time of Death
a. Facility Name (If not institution, gi	ive street and number)	1	LI EBERM	r Location of Death	January		2004
	Baltimore		Baltimon			4c. County	N/A
		e (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Fore
216-12-8423	1□M 2 F	83 Yrs.	Months Days	Hours Min.	06/19/	1924	Country) MD
Jsual Residence of Decedent 0a. State 10b. County		10c. City, Town or I					
,	10 D E	7.					10d. Inside City Lim 1 ☐ Yes 2 📉
MD BALTIM Oe. Street and Number	IURE	BALTII					
	#211		10f. Zip Code	11000	1	0g. Citizen of W	·
1 POMONA EAST,	#311 12. Was Decedent E	ver in U.S. 13		21208	cify Voc or No	14 Raco	USA - American Indian.
1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 1 N	ło		lispanic Origin? (Spec an, Mexican, Puerto F	Rican, etc.)		k, White, etc.
3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	WHITE
15. Decedent's E (Specify only highest gr	Education	16a. Dec	edent's Usual Occup	pation		16b. Kind of Bus	siness/Industry
Elementary/Secondary (0-12)	College (1-4or 5-	life.	. DO NOT use retire	,	g		
			HOMEN	1AKER		OWN	HOME
7. Father's Name (First, Middle, Lasi	t)			18. Mother's Name	(First, Middle, I	Maiden Surname	9)
MAX		SHAR		SOPHIE		ALTER	
9a. Informant's Name/Relationship				and Number or Rural			
JEFFREY LIEBERMA Oa. Method of Disposition	N / SON	20b. Place of Disp					ILLS, MD 211
1 X Burial 2 ☐ Cremation 3 ☐		cemetery, cr	ematory or other pla	ce) ¦			City or Town, State
4 ☐ Donation 5 ☐ Other (Speci	**		N CIRCLE	02/01		BALTIMO	•
11. Signature of Funeral Service Lice	nsee	-	22. Name and Addre	- 001			ROS., INC.
23a. Part1. Enter the disease, or com	unligations that says ad	the death. Denot s					LLE, MD 21208
shock, or heart failure. List only mmediate Cause (Final	one cause on each line	e.	riter the mode of dyli	ig, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
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		inez State of Maryland / Department of	f Health and Mental Hy		2008 028
	R	For State Certificate of		Reg. 2. Date of Death	No. 2 3. Time of Death
Physicia		Decedent's Name (First, Middle,Last)		Month D January 28,	ay Year 0610 hrs
Examir		Antonio Martinez-Martinez	the City Town or Legation of Dogth	January 20,	4c. County of Death
	4	a. Facility Name (if not institution, give on our and normal)	4b. City, Town, or Location of Death Aberdeen		Harford
		I-95 SB @ Mile 86.5		0. Date of Birth	MM/DD/YYYY) 9. Birthplace (State or
Funeral		. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	1	Foreign Mayico
Director		N/A 1XM 2 F 28 Yrs		Jan.17	, 1980 Country)
	h	Isual Residence of Decedent			10d. Inside City Limits
any	Γ	0a. State 10b. County 10c. City, Town or Local			1 X Yes 2 No
ihow Ge.	_	Maryland N/A Balti	more		
arylar 8a-f s at on	Director	0e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
or 2	핅	7001 Dieldement Dond	21215		Mexico
ith th		7001 Fieldcrest Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. W.	as Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
ath w	Funeral	1 Never Married 2 XMarried Armed Forces? If `	Yes, specify Cuban, Mexican, Puerto	ican, etc.)	
er de		3 Widowed 4 Divorced If Yes, Give Yaar	Yes 2 No specify:	Louis	Specify: Mexican
rs aft	<u>و</u>	15 Decedent's Education (Specify only highest grade completed) 16a. Decede	ent's Usual Occupation (Give kind of w		6b. Kind of Business/Industry
"nat	ē.	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use retir		
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with with giene her t	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Ma	aiden Surname)
filed Hy	Be C	Celso Martinez	Anna Ma		
212 Ild be Menta nark even	0	19a. Informant's Name/Relationship (Type, Print)	ng Address (Street and Number or F	Rural Route Numb	er, City or Town, State, Zip Code 1117
Shou and 1	-	Tereso Ramos /Uncle-in-law 9547	Winands Road	Owings	Mills, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	-	20a Method of Disposition	soluen (name or	Date	20c. Location - City or Town, State
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3Day 08^{Year} 10:50pM McCorkle Jr. William Abner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) NA Baltimore Joseph Richey House 8. Date of Birth (Month, Day,) 10 12 9. Birthplace (State or Foreign Country) MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Year) Min. Months Days Hours 1**X** M 2□ F Yrs. 61 46 212-80-9807 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 XYes 2 No Baltimore NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 21224 12. Was Decedent Ever in U.S. Armed Forces? 6213 Shipview Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ${rak U}\, {rak n}\, {rak k}$ 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Unknown Chef 12 th Grade Α A Degree 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Williamson Lillie McCorkle W. Abner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Kingway Rd.

2/4/08

22. Name and Address of Facility March F/H East

Physician /Medical

Examiner

Physician

/Medical

Examiner

10a. State

MD

20a. Method of Disposition

Director

Completed by Funeral

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

1/31/08

enphace

MCCOPRE

P.O. Box 68760,

Division or Vital Records,

To the Hospital

or Attending Physician: The law requires that the death certificate be executed the attending physician and After this certificate has been signed by the attending funeral director, page 2 should be detached for use a death. filled in by the within 24 hours after death To the Funeral Director:

1101 E.North Ave Baltimore, MD 21202 nelle 23a. Part1. Ent if the disease, or complications trial caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. HIV /AIDS

Due to (or as a consequent of): Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23d. Date of delivery 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 ☐ Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 | Yes 2 | No 3 | Probably 4 Unknown Be Completed 24a. Was an autopsy perform 1∐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury at Work? 27. Manner of Death (Month, Day Year) Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif

638

Greenmount Cem

W. 20b. Place of Disposition (Name of cemetery, crematory or other place)

State

Registrar

n who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature 31. Date filed (Month, Day, Year)

19a. Informant's Name/Relationship (Type. Print) in Law Gertrune McCorkle-Marksey

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Licensee

Baltimore, MD 21220

20c. Location - City or Town, State

Approximate Interval Between Onset and Death

EARS

Baltimore, MD

Month

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

				Please	Type or Prir					-		•		
			For State Registrar		State of Ma	aryland		artment of I <i>rtificate of</i>	Health and Death	Mental Hy	/gieno Rea. No	2002	028	317
			Decedent's Name	(First, Middle, Las	st)					2. Date of D	eath		3. Time of	Death
	Physicia /Medic		С	harles	Bruce Mon	rris				Febru	ary	1 3-00	8 5:36	PM
	Examin	- 45	4a. Facility Name (If r	4		1.0		P 1	or Location of Deat	h	40	County of Deat	h)
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Ur								G C N If Under 1 Year			irth	Anne A	hplace (State of	Foreign
	Funeral Director	ector 075-30-7301 1XIM 2LIF 70 Yrs. Montal Says Hours Oct 16, 193) Co	untry) nington,	DC		
	and w		Usual Residence of D	Decedent 10b. County		10c. City,	Town or L	ocation					10d. Inside Cit	v Limits
	Manyla f sho jed at	tor		Anne Aru	ınde 1		Ga	mbrills					1 □ Yes	·
	or 28a	Director	10e. Street and Numl			1		10f. Zip Code			10g. C	itizen of What Co	untry?	
	ath wil		2262 Mist	wood Cir					L054			United S		
	items items ner m	Funeral	11. Marital Status1 ☐ Never Married	d 217 Marriad	12. Was Decedent Armed Forces?		. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	 Race - Ame Black, White 		
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show ilcal Examiner must be notified at	by	3 ☐ Widowed 4		1 ⊠ Yes 2 □ I If Yes, Give Year or Dates:	***		1 ☐ Yes 2 🔀 No	Specify:			Specify: Wh	nite	
2-0	72 ho 'natur dical	Be Completed		15. Decedent's Ed y only highest gra			16a. Dece	edent's Usual Occu	pation during most of wo	rking	16b. I	Kind of Business/	Industry	
121	within iene. than " the Med	duu	Elementary/Second	dary (0-12)	College (1-4or 5	5+)		il Servic				ters for	Medica	re
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Baltimore,	Pages nent of h int; if ite			Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State	- 1	-	matory or other pla n Nat Cei	netery 3/	18/2008	A	rlington	ı. VA	
alti	permit. Pages Department of Important: If i any Injury or o		21. Signature of Fun-			1			ess of Facility n Funeral			_		
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			23a. Part1 Enter the shock, or heart Immediate Cause (Fi	failure. List only	plications that caused one cause on each li	ne.		ter the mode of dy	r		arrest,		Approximate Interval Bety Onset and D	veen
,	Physician /Medical		disease or condition resulting in death)		a. Due to (or as	Propseque	ence of):	17 -	a.lu	V-8				
	Examiner		Cognostistly list cons	ditions	ANO)	cic	e i	ncepl	halal	path	Y			
	7 W 5	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents. A C P // G to n P // R Umonia											
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(687	ng ph	Physician/Medica	IF FEMALE:	1	-									
Вох	attendi for use	ian/	23b. Was decedent p		23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	☐Ectopic pregnan	су			23d. Date of de Month		'ear
P.O.	the de	ysic	1 □ Yes 2 □ 9 □ Unknown	No	9□Unknown	ume or de	aui 5	_ Other (specify)_						
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	2041		30. Name and address	ss of person who	ompleted cause of d		23a) (Type	, Print)			126	rvar	y 1 2	000
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8	Sta Registr		31. Date filed (Month	0.00	32. Registr	ars Signati	ure	de						

			1 - For State Registrar	State of Mar		artment of Heal rtificate of Dea		al Hygier Reg. 1	2000	02818
	L. Burnel		1. Decedent's Name (First, Middle, Last)				te of Death		3. Time of Death
þ	Physici /Medio		MARY L.				J	AN 29	2008 Year	8:32 P M
}	Examin	er	4a. Facility Name (If not institution, give		DAMED	4b. City, Town, or Loca			4c. County of Death	
			NATIONAL NAVAL 5. Social Security Number 6. Se		ENTER In yrs. last birthday)	BETHE		e of Birth	MONTGOM	
h	Funeral Director			M 2√2 F 80	Vre		ours Min. (Mo	onth, Day, Yes 04–192	7 Macc	place (State or Foreigr ntry) achusetts
	PL _		Usual Residence of Decedent				104	04-192		
	arylar show	ř	10a. State 10b. County		0c. City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	the M 28a-f notifie	Director	MD Anne Aru 10e. Street and Number	nde1		Odenton 10f. Zip Code		10- /	0141	
	with with the r						0		Citizen of What Cou	•
	death ms 2:	Funeral	1905 Battle Way	12. Was Decedent Eve	er in U.S. 13.	2111 Was Decedent of Hispan If Yes, specify Cuban, Me		s or No-	Inited Sta	can Indian,
20	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It and Mental Hygiene. ?? Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give			exican, Puerto Rican, i pecify:	etc.)	Black, White,	etc.
2-0036	hours tural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		dent's Usual Occupation		405	Wh	ite
Ç	in 72 n "na Aedio	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	kind of work done during DO NOT use retired)	g most of working	100.	Kind of Business/In	austry
717	d with giene ir thai	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Teled	communication	on Speciali	ist	U. S. Gov	vernment
and	al Hyl	Be C	17. Father's Name (First, Middle, Last)			18. I	Mother's Name (First,	Middle, Maid	len Surname)	
ya	ould by Ment arkec	10	Edward J. Led				Mary C.			
Ma	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (T)	rpe. Print)	19b. Mailir	ng Address (Street and N				code)
	1 an Heal em 2		Joe Henry McDonald 20a. Method of Disposition	/ Husband	20b. Place of Dispo	Battle Way	Odenton,		nd 21113 Location - City or To	own State
more,	90=5		1 ☑ Buria! 2 ☐ Cremation 3 ☐ F		cemetery, cire	natory or other place)			,	
baitil	permit. Pag Department Important: I any injury o	1.2	21. Signature of Funeral Service Licens			Nat. Ceme. Name and Address of I		08 Ar	lington,	Virginia
ă	lmp any any	6	(Amas))alus	Pho P	onaldson Fur 11 Annapoli	neral Home	& Cre	matory, P	.A. d. 21113
Ċ			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused in	e death. Do not ent	er the mode of dying, su	ch as cardiac or respir	ratory arrest,	, mary ran	Approximate
,	Physician		Immediate Cause (Final disease or condition		LARGE B	CELL LYMPHOR	Ma			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a o		GROW BINGINA				
	49	7	Sequentially list conditions,	Due to (or as a c	onsequence of):					
	petr Lisu	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Duc 10 (01 45 4 5	onsoquence on.					
,	n no rial tra	Еха	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):					
00/00	ificate be executed physician and state burial transit	edical	•	i						
T	ertifica ling ph e as t	Med	IF FEMALE:							
Š	The law requires that the death cert ate has been signed by the attendingage 2 should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf 1☐Live birth 2 4☐Pregnant at tin	Fetal death 3	Ectopic pregnancy			23d. Date of deliv Month	ery Day Year
j	the de	ysic	1 ☐ Yes 2 ▼ No 9 ☐ Unknown	9☐Unknown	ne of death 51	Other (specify)				
r,	s that ned by		Part II. Other significant conditions co	ntributing to death but r	not resulting in the u	nderlying cause given in l	Part I. 23	e. Did tobacc	o use contribute to t	he cause of death?
cords,	quires en sign uld be	ed by						1 🗌 Yes	2 No 3 □ Prol	bably 4
) ၁	law re	Completed					24	a. Was an	24b. Were auto	opsy findings available
	The ate he	E O					1	autopsy performed?] Yes 2t∏≀	? death?	2 No
ומ	cian: ertific ector,	Be	25. Was case referred to medical examiner?				Place of Death (Chec			
5	Physic this o	<u>٩</u>	T les 2 X No		2 ER/Outpatier		□ Nursing Home 5			<i>5y)</i>
5	ding I	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes		scribe how in	jury occurred	
2	Attender death	ficat	3 Suicide 6 Could not be	28e. Place of injury				ation (Street	and Number or Run	al Route Number.
S	al or al al Direction of in b	Certification:	4 ☐ Homicide determined	building, etc. (Specify)		City	y or Town, Sta	ate)	, , , , , , , , , , , , , , , , , , , ,
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physics (Check only 2 Medical Exami	sician: To the best of r	ny knowledge, death	n occurred at the time, da	ate and place, and due	to the cause	e(s) and manner as s	stated.
	the h	Medical	one)	and manner stated	d.					
	S Wil		29b. Signature and title of certifier	1 .	. ^	29c. License num			Date signed (Month,	
	.1	1	30. Name and address of person who co	1300	Λ, ρ , h (Item 23a) (Tyne		0316 (VA)		anyany 30	5002
	12		STEVEN P. ARMBR		MC USN_	MALLOM	AL NAVAL M DA MD 2088		CENTER	
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's	Signature		2000	2 2000		
	Registra	ar	FEB 0 4 2008	production .	, O' B	No.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HENRY T. MCFADDEN 31, JANUARY 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death MANOR CARE TOWSON TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 5/27/1920 030-10-8337 87 MASSACHUSETTS Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 E. JOPPA ROAD PH17 21286 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 ▼ No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE <u>MERCHANT SEAMAN</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HENRY MCFADDEN NELLIE WELBY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed bepartment of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, the

1 - For State Registrar

10a. State

MD

EMMA G. MCFADDEN/WIFE

4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Licensee

1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State

20a. Method of Disposition

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

the Medical

Director

Funeral

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Completed

Be 2

with the Maryland

within 72 hours after death

Baltimore, Maryland 21215-0036

certificate be executed physician attending plant of for use as certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division or Vital Records, P.O. Box 68760

\perp	Tray a mar	70001	0721	LOCH RAVEN E	LVD. IOWS	JN , 1711 2	1200
	23a Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the death. Do no ne cause on each line.	t enter the m	ode of dying, such as cardi	ac or respiratory arrest,	7	Approximate Interval Between Onset and Death
	disease or condition	CEREBRO	175	CULAR.	MROMI	50315	
	resulting in death)	Due to (or as a consequence of	KE				weeks.
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of	:				
F	that initiated events resulting in death) Last	Due to (or as a consequence of)	:		1111		
	zob. was deceder pregnant	23c. If yes, outcome pf pregnancy	0.00			23d. Date of de	livery
	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	3□Ectopic 5□Other (Month	Day Year
- F	Part II. Other significant conditions con	ntributing to death but not resulting in the McCle Tus.	ne underlying	cause given in Part I.		co use contribute t	o the cause of death? robably 4 nknown
-					24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
	25. Was case referred to medical			26. Place of De	eath (Check only one)		
1	examiner? 1 ☐ Yes 2 No	lospital:	atient 3 🗆 [Home 5 ☐ Residence	6 DOther (Sp.	acifu)
2	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tin Inju		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		uny)
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm building, etc. (Specify)	, street, facto	ry, office	28f. Location (Street City or Town, St	t and Number or R tate)	ural Route Number,
2	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my knowledge, oner: On the basis of examination and/oner and manner stated.	leath occurre or investigation	d at the time, date and place, in my opinion, death occ	ee, and due to the cause curred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
2	29b. Signature and title objectifier	i de		9c. License number D-00/260	29d.	Date signed (Mon	th, Day, Year)
3	60. Name and address of person who co	mpleted cause of death (Item 23a) (Ty	pe, Print)	R DV. TO	WSON	MD.	21204

204 E. JOPPA ROAD

OFOI LOCK DAVEN DIVE

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY, INC.

PH17

Date

2/2/2008

22. Name and Address of Facility THE JOHNSON FUNERAL HOME,

TOWSON, MD

TOLICON

21286

20c. Location - City or Town, State

CATONSVILLE, MD

State Registrar gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month John Jerry Moore 24,2008 January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex . Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Months Days Hours 1**⊠**M 2□F 213-24-0024 78 10/28/1929 Salisbury, MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Worcester Whaleyville 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8035 Old Ocean City Road 21872 USA 12. Was Decedent Ever in U.S. Armed Forces? 1.0.6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ¹2□No 1964 1 X es 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced 1969 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Marine COrp US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Lane Sarah Lane 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Flural Route Number, City or Town, State, Zip Code) 8035 Old Ocean City Road Whaleyville, MD 21872 Myrtle Moore/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Nonation 5 ☐ Other (Specify) University 1/28/08 Washington, DC 22. Name and Address of Facility Austin ROyster FUneral Home Howard Signature of Europeal Service I 3821 14th Street, N.W., Washington, DC 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he or failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a surresquence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) □Yes 9☐Unknown 9 Unknown nt conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred Injury

Physician /Medical Examiner Examine The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

show

r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be n

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other v

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Injury o

Director

Funeral

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Completed

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sician and burial-tran the attending ph detached page 2: this completely filled in by the funeral After

Physician/Medical

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Completed

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Certification: To

Medical

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

death

1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Natural 2 Accident

29a. Certifier

31. Date filed (Mo

25. Was case referred to medical examiner?

5 Pending investigation 3 ☐ Suicide 6 ☐ Could not be 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Hegistrar's Sign

Date of Injury (Month, Day Year)

28c. Injury at Work?

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Donartment of Health and Montal Hygiene

			1 - For State Registrar	State of Mai	-	epartment of F Sertificate of		ental Hygle Reg.	2000	02821				
	Physici	an	Decedent's Name (First, Middle, Last	,	- Mi			2. Date of Death Month	Day Year	3. Time of Death				
	/Medio		4a. Facility Name (If not institution, give	ngelina An street and number)	n waggi		r Location of Death	Jan	29, 2008 4c. County of Death	7:30 A ^M				
			Clifton Woods	Assisted Livi	ng		Silver Spring		Mont	gomery				
	Funeral Director			X 7. Age	(In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Cou	place (State or Foreign ntry)				
			Usual Residence of Decedent	/	90			Aug 30,	1917	NY				
13-0U35 172 hours after death with the Maryland "natural", or items 23a or 28a-f show idleal Examiner must be notified at		7	10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits 1 ☐ Yes 2 No				
		Director	MD How 10e. Street and Number	ward		10f. Zip Code	Clarksville	100	Citizen of What Cou					
			6032 Winter Grain Path			1000 449 0000	21029		onizon or what ood					
	tems (Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White,					
35	ırs afte al'; or i xamlı	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	' I	1 ☐ Yes 2 No	Specify:		Specify: Wh	nite				
5-0036	72 hou natura Ilcal E	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. De	ecedent's Usual Occup	oation during most of working	168	o. Kind of Business/Ir	ndustry				
12	be filed within 72 ho ital Hygiene. d other than "natu event, the M. dloal	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	`iii	ive kind of work done e. DO NOT use retired			1 1 0					
7 0	e filed value of the cother i	ပိ	17. Father's Name (First, Middle, Last)			Adminstra	18. Mother's Name		Local Gorden Surname)	vernment				
/land	2 should be and Mental Is marked c	To Be		Marga	ret Caraccio									
Mar	2 shoul 1 and M 1s mar! raumati		19a. Informant's Name/Relationship (T)	pe. Print)	19b. M	ailing Address (Street	and Number or Rural	Route Number, C	ity or Town, State, Zi	o Code)				
a,	1 and 3 Health em 27		Robert Maggio 20a. Method of Disposition	Son	20b. Place of Di	032 Winter Gra	Da		1029 : Location - City or T	own State				
Saltimor	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or other traumatic once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, (crematory or other plac	ce)	0, 2008	•	, Maryland				
	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licens		All Count	y Cremation Ser 22. Name and Addre		10, 2000	Oykesville	, maryiana				
		0.0	- Hellouphous	MD 21043										
	Dharatatan 1	1 8 18	23a. Part1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Death States Cause (Final Action Control of Cause (Final Action Contro											
	Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequence of):	pathy				years				
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4	ist 🔀 ed	Examiner	squarillarly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	7								
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200	attend for us	Physician/N	in the past 12 months?	3c. If yes, outcome pf 1□Live birth 2 4□Pregnant at tir	☐ Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)	1		23d. Date of deliv Month	ery Day Year				
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Ď,	law requires that the death cer as been signed by the attendin 2 should be detached for use		Part II. Other significant conditions co	ntributing to death but	not resulting in the	e underlying cause give	en in Part I.		co use contribute to t	\ /				
SOLOS,	requi	eted	Hima						2 No 3 Pro					
ב	he law e has l	Completed by	Hypirliusion					24a. Was an autopsy performer	1? death?	opsy findings available impletion of cause of				
ō	lan: T	a l	25. Was case referred to medical				26. Place of Death	1□ Yes 2 🖎	No 1 □Yes	2 No				
5	hysic this ce al direc	To B	TLI Tes 2LANO	lospitai: 1 ☐ Inpatient		tient 3 DOA Othe	4 U Nursing Hom			(15515+c) (1) 11/11/16				
	ding F h. After funera	ü	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day)	/ear) 28b. Time Inju	y Worl	y at k? Yes 2 □ No	d. Describe how i	njury occurred)				
2	Atten r deat ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined			street, factory, office		f. Location (Stree	t and Number or Run	al Route Number,				
5	Ital or irs afte rai Dir lled in	Cert		building, etc.				City or Town, S	·					
	Hosp 24 hou Fune stely fil	edical	29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best of e	xamın <i>a</i> tıon and/o	eath occurred at the tir r investigation, in my o	me, date and place, ar ppinion, death occurre	nd due to the caus d at the time, date	e(s) and manner as s and place, and due t	stated. to the cause(s)				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Mec	29b. Signature and title of certifier	and manner state	u.	29c. License	e number	29d.	Date signed (Month,	Day, Year)				
			1/ 2 puros			133	2332		an 301	8				
	10		30. Name and address of person who co	empleted cause of dea	th (Item 23a) (Tyr	e, Print)	N. S.1			000-0				
	Sta	e	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	il Digital	we of	ver spr	IN MD	20409				
	Registra		FEB 0 4 2008	Alesta.	s Signature	NO.			~					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State Registrar	State	of Mary	land / Depa <i>Cei</i>		nt of H <i>te of L</i>			lental Hy	giene Reg. No.	008	028	322
			1. Decedent's Name (First, Middle	, Last)							2. Date of D	eath Day	Vaar	3. Time o	f Death
	Physicia		Merle	Mere	-						Month	31	OS Vear	7:	15 pm
	/Medic Examin		4a. Facility Name (If not institution,	give street and n	number)		4b. City	, Town, or	Location	of Death			County of Dea	th	
	LAUIIIII		Transitions He	alth Car	re		Syke	esvil	1e			C	arroll		
	Funeral	-		6. Sex	7. Age (II	n yrs. last birthday)	If Unde	er 1 Year	If Unde	r 24 Hrs.	8. Date of B	rth		thplace (State	or Foreign
	Director		218-10-3505	1□M 2 X □F	86	Yrs.	Months	Days	Hours	Min.	Feb 26		1 1	ndiana	
	D		Usual Residence of Decedent											T	
	how		10a. State 10b. County			c. City, Town or Lo								10d. Inside 0	
	a-f-a	cto	PA Adams	}		Biglervil	ше							1016	s 2 XNo
	th th	Director	10e. Street and Number				10f. Z	ip Code					zen of What C	ountry?	
	th wi	ai	260 Winding Bro	ok Road				1730	07			USA			
	dea	Funeral	11, Marital Status	12. Was De	ecedent Eve Forces?	r in U.S. 13.	Was Dec	edent of Hi	ispanic O	rigin? (Span)	ecify Yes or N Rican, etc.)	0-	 Race - Am- Black, Whi 		
9	or it	F	1 Never Married 2 Marri	ed 1 ☐ Yes If Yes, 0	s 2 TNo Give X		1 ☐ Yes	2 No	Specify	<i>r</i> :		ŀ	Specify: wh:	i + 0	
ဗ္ဗ	ural',	d by	3 X Widowed 4 ☐ Divorced	Year or	Dates:										
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ᆵ	ould be filed within 72 hours after death with the Maryland Mental Hydiene. arked other than "natural", or itema 23a or 28a-f ahow afte avant, the Madical Examiner must be notified at	Be	Arthur W. Hall	_dS()							. Morr		Surramo		
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ď.	1 and 2 Health a Am 27 In ther tree		Wayde Meyer (st	.epson/	1.						DIGLE.	-	e, PA		-
0	Pages 1 nent of H int: If its iny or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal fro	m State	20b. Place of Dispo cemetery, crei	matory of	other plac	e)				imore,		
Baltimore, Maryland 21215-0036			4 Donation 5 ☐ Other (Sp			Lorraine									_
a a	permit. Departn Imports any Inju		21. Signature of Funeral Service I										Home	& Chape	1
_	20 E 3 9		▶ Gardingt				-				ville,		.1/84		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause or	t caused the n each line.	e death. Do not en		0				arrest,		Approxima Interval Be Onset and	etween
	Pnysician	0. 7	Immediate Cause (Final disease or condition	R	saci	ren'al		Inv	ren	10 M	19			Oliset and	Death
	/Medical		resulting in death)	Due t	to (or as a c	onsequence of):									Ti fi
	Examiner		Sequentially list conditions	b											
	p =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Diet	to (or as a in	chrisquence of):									
	nd trans	am	that initiated events	c											
Ö,	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ũ	resulting in death) Last	Due	o (or as a c	onsequence of):									
8760,	ate b hysic the b	dicai		d.											
9	n certific anding p use as t	Mec	IF FEMALE:	1										-	
Вох	eath certifi attending p for use as	an/	23b. Was decedent pregnant in the past 12 months?		e birth 2	Fetal death 3		pregnancy	,			:	23d. Date of de Month	elivery Day	Year
<u>.</u>	the at	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pre 9 □ Uni	ignant at tim known	e of death 5	Other (specify)						,	
P.O.	that the de ed by the detached	P.			d ab - 1 - A -				in O		220 Dia	I tobacco i	use contribute	to the cause of	death?
Ś	res tha igned I be det	۵	Part II. Other significant condition	ans contributing to	death but n	ot resulting in the t	ınderiyinç	g cause giv	en in Pan	1.		Yes 2		robably 4	
ב	w requir been si should I	Completed									4	1185 21		100abiy 4 E	Control
ပ္ပ	law r as be 2 sh	pie									24a. Wa aut	opsy	24b. Were a	utopsy finding completion of	s available cause of
<u> </u>	The ate h page	NO.									per 1 ☐ Yes	formed? 2√2 No	death?		
ita	Physician: r this certifica ral director, i	Be (25. Was case referred to medical examiner?							ce of Deat	h (Check only	one)			
<u></u>	nysic nis ce I dire	은	1 ☐ Yes 2 € No	Hospital: 1 (□Inpatient	2 ER/Outpatie	nt 3 🗆 I		461	dursing Ho	ome 5 ☐ Re	sidence	6 □Other (Sp	ecify)	
0	neral		27. Manner of Death ∠T⊇Natural 5 ☐ Pendin	28a. Da	te of Injury onth, Day Y	ear) 28b. Time o	of	28c. Injur Wor	y at k?	•	28d. Describe	how injur	ry occurred		
<u>.</u>	ittendir death. ctor: Al y the fu	atic	2 ☐ Accident investig	gation			М		Yes 2[□No					
Division of Vital Records,	il or Attand after death Director: / d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	inad 286. Pla	iding, etc. (At home, farm, st Specify) 	reet, fact	ory, office				(Street and	nd Number or F)	Rural Route Nu	mber,
	rs aft	Se													
	Hospital or Attanding 24 hours after death. Funeral Director; Afte tely filled in by the fune	cai				ny knowledge, deal amination and/or in									(s)
	To the Hospital or Attending Physicien: The law within 24 horus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	one)	and m	anner stated										
	Vit To Con	2	29b. Signature and title of certifie	Г			1	29c. Licens	e numbe	2			te signed (Mor		
•	7		10-					リリ	>1	45		-	11108		
0	1		30. Name and address of person	who completed ca	ause of deat	10	Print)		0	. 1	10%	h	iniste	0.01	100
1			IAMIQ M	HHM	(100)		100	C	1CUL	~ 4	VUE.) (rm	101771	7 41	, 2 ,
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	Telest.	ar .	LEDOS	· Sui	Sel Sel Se	2 80 30									

		1- For Amend Item 1 State of Mary 1970	Certificate of Death	Mental Hygiei	0000 00000
Phys		1. Decedent's Name (First, Middle, Last) Jessie Nealy	Neares	2. Date of Death	Day Year 3. Time of Death
	dical niner al	4a. Facility Name (If not institution, give street and number) ESTOW MOMORIAL HO 5. Social Security Number 6. Sex 7. Age (In yrs. last.)	Months Days Hours Mi	ath rs. 8. Date of Birth	4c. County of Death ALBOTT ar) 9. Birthplace (State or Foreign Country)
death with the Maryland ms 23a or 28a-f show can rmust be notified at			own or Location verna Park 10f. Zip Code	Dec 4, 19	30 Maryland 10d. Inside City Limits 1 □ Yes 2 No Citizen of What Country?
partitions, interfyiating ZIZIS-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notified at	eted by Funeral D	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 4 □ Divorced 1 □ Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	21146 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 Yes 2 No Specify: 3a. Decedent's Usual Occupation (Give kind of work done during most of w	16b	USA 14. Race - American Indian, Black, White, etc. Specify: black Kind of Business/Industry
d be filed within 7 et al. 8 et al. 12 et al. 8 et al. 12 et al. 1	o Be Completed	Elementary/Secondary (0-12) College (1-4or 5+) 10 0 17. Father's Name (First, Middle, Last) Frank Williams	nursing aide 18. Mother's N	ame (First, Middle, Maid	
ages 1 and 2 shoul nt of Health and Me to 1 free 27 is mark or other traumati	J.	19a. Informant's Name/Relationship (Type. Print) Easton Memorial Hospital 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State	9b. Mailing Address (Street and Number or 219 S. Washington St of Disposition (Name of tery, crematory or other place)	Rural Route Number, Cit	y or Town, State, Zip Code)
permit. Pages Department of Important: If it	ouce ouce	4 Donation 5 → ther (Specify) 21. Signature of Funeral Service Licensee Wardes, Director	State and arony arboa. Baltimore, MD 21		altimore Street
cate be executed / Medica Examine bhysician and bhysician and the burial-transit	dical Examiner	23a. Part. Enter the disease, or complications that caused the death. Do show or heart failure. List only one cause on each line. Immediate the efficient disease or condition resulting in death) Sequentially list conditions, it any, beauting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence).	A YOCARDIAL INF- e of):		Approximate Interval Between Onset and Death 3 HOVPC
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
w requires that the de been signed by the s	Ď	Part II. Other significant conditions contributing to death but not resulting TYPCZ DIABCTES Mell	1745	23e. Did tobacc	o use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
	e Completed	ENOSTAGE ROWAL DISEI HYPERTONSION 25. Was case referred to medical		24a. Was an autopsy performed 1 Yes 2 1	Ab. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
Attending Phy: r death. ector: After this by the funeral di	Certification: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 Hospital: 2 Hospital: 2 Hospital: 2 Hospital: 2 Hospital: 3 Hospital: 4 Hos	Outpatient 3 □ DOA Other: 4 □ Nursing . Time of Injury 28c. Injury at Work? 1 □ Yes 2 □ No	Home 5 Residence	jury occurred and Number or Rural Route Number.
To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death oc	ce, and due to the cause curred at the time, date a	c(s) and manner as stated. and place, and due to the cause(s)
To with	2	29b. Signature and title of certifier 30. Name and address of person who completed gause of death (Item 23a)	29c. License number 0 46 36 0	2 1	Oate signed (Month, Day, Year) NVA RY ZY, ZOOS
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	D SOUN VETERALS H	16HWAY MIL	LOKSVILLE MD 21/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c 22 per fb 8876 2-4-08 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Year OX **Physician** DANIEL PELTZER 3 . 50AN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner REISTENSTOWN

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Hours | Min. | (Month, Day, Year) TIMORE ARE CHERRYWOOD - UTUREC 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F Yrs. 215-32-1403 Mar 16, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23s or 28s-f show any Injury or other traumatic event, Ita Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 ☐ Yes 2√☐ No Hampstead Director MD Carroll 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21074 USA 1719 Broadbeck Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status Bfack, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 NDivorced Completed unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Efementary/Secondary (0-12) plumbers helper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Grace Helwig Spurgeon Peltzer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1719 Broadbeck Road Hampstead, MD 21074 Lawrence Peltzer/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2-5-08 Reisterstown, Md. All Saints Cem. 4 □Donation 3 140 21. Signature of Euneral Servi Flyne Angered Hone 611824 Reistarstown Rdt Director 21201Reisterstown, Md. 21136 Approximate Interval Between Onset and Death Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) olon lung **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Completed by Physician/Medical 88 *fF FEMALE* 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year signed by the at Id be detached for 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been si should 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No s certificate hes b lirector, page 2 s 2 3 No 1 Tes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 ☑ No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) : After thi funeral of 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Naturaf 5 Pending 1 Yes 2 No м death. i Director: / 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after d illed in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and tixe of certifier on who completed ause of death (Item 23a) (Type, Print) 30. Name and 31. Date filed (Month, Day, Year) Aegistrar's Signature State Registrar

			State of M. 1 - State Amend 5, 19a, perff, 88/6, 2	74/08 TT <i>Ce</i>	rtificate of D	Death	Reg	ZUU8	02825
	Dhusisi		1. Decedent's Name (First, Middle, Last)	1		2.	Date of Death Month	Day Yeer	3. Time of Death
	Physici /Medio			nardson			01	27 08	830 AM
	Examir	ner	4a. Facility Name (If not institution, give street and number)	Home	4b. City, Town, or I			Balking	
			5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)			Date of Birth		hplace (State or Foreign
	Funeral Director		217–68–4859 1≅ M 2□ F 4	Vre	Months Days	Hours Min.	(Month, Day, Y June 20	ear) Co	Maryland
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	arylar show	_	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits 1 ☑Yes 2 ☐ No
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	death with the Maryland rms 23a or 28a-f show rmst be notified at	Funeral Director	1012 Pennsylvania Aven	#202	10f. Zip Code 21201			SA	unity?
	Jeath	era	11. Marital Status 12. Was Decedent Armed Forces?			spanic Origin? (Specif n, Mexican, Puerto Ric	y Yes or No-	14. Race - Ame	
9	n 72 hours after death with the Marylan "natural", or llems 23e or 28e-f show edical Examiner must be notified at		1∑ Never Married 2 Married 1 ☐ Yes 3€	No I			an, etc.)	Black, White	
5-0036	72 hours after natural', or Ite	ρ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify101.0	
	natu	Completed	 Decedent's Education (Specify only highest grade completed) 	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	urina most of workina	16	b. Kind of Business/	Industry
2121		ф	Elementary/Secondary (0-12) College (1-4or 5	i+)	,			Private	Industry
d 2	Hygie Hygie other		10th grade 17. Father's Name (First, Middle, Last)	ь_ьа.	borer	18. Mother's Name (F			Induber y
lan	ould be to Mental I warked or	To Be	Willie Richardson			Odell H	endric	KS	
Maryland	sh sh	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a	nd Number or Rural R	oute Number, C	ity or Town, State, 2	Tip Code)
	l and 2 lealth in 27 i		Odelle Richardson/ Mot	ther 1012		Vania Av			
altimore,			20a. Method of Disposition Surial 2 □ Cremation 3 □ Removal from State	cemetery, crea	matory or other place			c. Location - City or nsdowne .	Maryland
Hin	permit. Page Department c Important: If any injury or once.		* 4 □Donation 5 □ Other (Specify) 21. Signature of Fugferal Service Ligen ee						
Ba	permit. F Departm Importar any inju		Delay Harri	5	240 Reis	terstöwn			meral Home Md 21215
	Fnysician /Medical Examiner		23a. Part Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lift Immediate Cause (Final disease or condition resulting in death) a. Alp S Due to (or as	a consequence of):	ter the mode of dying.	, such as cardiac or n	espiratory arrest		Approximate Interval Between Onset and Death
8760,		ilcal Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events c.	a consequence of): a consequence of):					
P.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. tf yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	res that igned by be deta	y Pr	Part II. Other significent conditions contributing to death b	ut not resulting in the u	nderlying cause giver	n in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
rds	v require been sig should b	edt	Encephalopathy, n	nalautri	tron		1 🗆 Yes	2.200 3□Pr	obably 4 Unknown
	The law retate has be page 2 sho	Completed by					24a. Was an autopsy performe 1 Yes 2	prior to death?	topsy findings available completion of cause of 2 No
/ita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	- 7.5	- 1	26. Place of Death (0			
of	Physical this call dir	70	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie 27. Manner of Death 28a. Date of Inju			4 a dising Home	5 Residence I. Describe how		cify)
o	ding h. After funer	ton	1. Natural 5 ☐ Pending (Month, Day	Year) Injury	Work?	? es 2 \(\subseteq No	. 50301150 11011	injury cocumou	
/isi	Attending or death. ector: After by the fune	fica	3 Suicide 6 Could not be	ury - At home, farm, sti			Location (Street	et and Number or Ru	ıral Route Number,
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner sta	examination and/or in	h occurred at the time vestigation, in my opi	e, date and place, and inion, death occurred	due to the caus at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	부분들은	9	29b. Signature and title of certifier	1	29c. License		29d	Date signed (Monte	h, Day, Year)
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<i>I</i> '	J S S S S S S S S S S S S S S S S S S S	2	30. Name and address of person who completed cause of d	eath (Item 23a) (Type,	Print)				
ľ	Sta		30. Name and address of person who completed cause of d 1	eath (Item 23a) (Type,	Print)		Balk		vo 2/217

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician JANUARYDaysi, EYANA STELLA S. ROWLAND 10:10FM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center If Under 1 Year If Under 24 Hrs.

Manthe Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕅 F Yrs. Director 329-16-2660 12/2/1922 CHICAGO, IL Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified Director BALTIMORE 1 ☐ Yes 2 ☐ No MD TOWSON 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 975 FAIRMOUNT AVENUE Funeral 21204 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 I 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: ş 3 XWidowed 4 ☐ Divorced Specify: WHITE Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSE AID HOSPTIAL ith and Mental Hygier 27 is marked other the traumatic event, the 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH SORDYL VICTORIA SPICEK ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) STEVEN ROWLAND/SON 975 FAIRMOUNT AVENUE TOWSON, other t MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial , 2 🔀 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) METRO CREMATORY, INC. 2/4/2008 CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List if yone cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death ATHEROSCLEROTIC CARDIOVASCULAR DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner DEMENTIA 2 YEARS Soque titally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1∐ Yes 2 1 No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this funeral (28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) non-poor Kio D31865 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIEN-DOOR KIOUNE M.D., 7601 OSLER DRIVE, TOWSON. MARYLAND 21204 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 0 4 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day MARY BARNES REID /Medical F<u>EBRUARY</u> 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE HOSPITAL BEL AIR HARFORD If Under 1 Year Months Days 5. Social Security Number Age (In yrs. last birthday, **Funeral** If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Months 1 ☐ M 2 🕱 F Yrs Director <u> 250–84–6059</u> 04-29-1929 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show Examiner must be notified Director MD BALTIMORE DUNDALK 10e. Street and Number 10f. Zip Code filed within 72 hours after death with ò 23a M-800 48475 Funeral 6840 BROENING RD 21222 or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 □ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ρ 1 ☐ Yes 2√2 No Specify: 3₩Widowed 4□Divorced "natural", Completed ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 06 COOK and 2 should be file of Health and Mental Hy tem 27 is marked. 17. Father's Name (First, Middle, Last) To Be 18. Mother's Name (First, Middle, Maiden Surname) other traumatic LEROY BARNES LOU INGRAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY G. REID/DAUGHTER 6840 BROENING RD, DUNDALK, MD 21222 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of permit. Pages Department of Important: If it any injury or or ST. PAUL CHURCH CEM. 02-06-2008 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1701 LAURENS ST., BALTO., MD 21217 23a. Part Inter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each i Immediate Cause (Final Physician erebra disease or condition resulting in death) /Medical Due to (or as a sequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): K pg as the burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant Por 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No signed by the at d be detached for 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ plnous Completed 24a. Was aп has page 2 autopsy this certificate perform Division or Vital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2₩No 1 Inpatient ဥ 1 ☐ Yes 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) uneral 27. Manner of Death 28c. Injury at Work? 28b. Time of After Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 2 Accident 3 🗌 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24

and manner stated

. Registrar's Signature

Yes 2 □ No 10g. Citizen of What Country? USA 14. Bace - American Indian Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry SCHOOL SYSTEM 20c. Location - City or Town, State LANCASTER, SC JAMES A. MORTON & SONS F.H., INC Approximate Interval Between Onset and Death nonth 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ∕24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) of person who completed cause of death (Item 23a) (Type, Print)

'In LYNCH MD Upper Chesapaake Hospfal

Year

2:28 A

Birthplace (State or Foreign Country)

SC

10d. Inside City Limits

2008

Registrar

State

29b. Signature and title of certifier

J. KRUIN 31. Date filed (Month, Day, Year)

FEB

0 4 MARY ROBINSON

Physician / Medical Examiner 4a. Facility Narde (If not institution, give street and number) 4a. Facility Narde (If not institution, give street and number) 4b. City, Town, or Location of Death BALT I MO RE 5. Social Security Number 6. Sex Yrs. 5. Social Security Number 1 Months Days Hours Min. 10a. State 1 10b. County A BALT I MO RE 10b. County A Part A Months Days Hours Min. 10c. City, Town or Location 10c. City, Town or Location 10d. Street and Number 1 10c. City, Town or Location 10d. Street and Number 1 10c. City, Town or Location 11d. Marital Status 1 1 Marital Status 1 1 Marital Status 1 1 Marital Status 1 Ma	e of Death nth Day Year (1.140 Day
Physician /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death GD D SAMAR) TAN HOSPITAL BALTIMORE Funeral Director Funeral Director Pure Not be part of the part of	Day Year 2008 4:40 PM 4c. County of Death BALTIMORE CITY of Birth, nth, Day, Year) 2.3, 1929 North Carolina 10d. Inside City Limits 1 XYes 2 No
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE Social Security Number 5. Social Security Number 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Whoths Days Hours Min. Who Da	BALTIMORE CITY 9. Birth place (State or Foreign Country) 1.23,1929 North Carolina 10d. Inside City Limits 1 128 Yes 2 No
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Elementary/Secondary (0-12) College (1-4or 5+) Cateteria Aide	II CA
Elementary/Secondary (0-12) College (1-4or 5+) Cateteria Aide	s or No- 14. Race - American Indian, Black, White, etc. Specify: Plank
	16b. Kind of Business/Industry
S 35 E F 1000 LILLOUE	Middle, Maiden Surname)
	Number, City or Town, State, Zip Code) 1. Balto. M.J. 21224
TMRurial 2 Cremation 3 DRemoval from State cemetery, crematory or other place)	20c. Location - City or Town, State 08 Crowns Ville, Md.
m & E & E & E & Worth Ave. To	eral Home, P.A. 3alto, Ma, 21216
23a. Part Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respire shock or heart failule. List only one cause on each line. Physician /Medical 23a. Part Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respired to the discusse or condition as a consequence of the discussion of the discussion and discussion as a consequence of the discussion and discussion are death. Do not enter the mode of dying, such as cardiac or respired to the discussion and discussion are discussed the death. Do not enter the mode of dying, such as cardiac or respired to the discussion and discussion are discussion.	atory arrest, Approximate Interval Between Onset and Death
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That initiated events resulting in death) Last Due to (or as a consequence of):	
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The law page 2 si page 2 si page 3 si page 2 si page 2 si page 2 si page 3 si page 2 si page 3 s	a. Was an autopsy performed? Yes 2 ☒ No 2 ≥ No 2 □ No 2
25. Was case referred to medical examiner? 1 Yes 2 No	Residence 6 □Other (Specify)
C 2	scribe how injury occurred
S s & E = 1	ation (Street and Number or Rural Route Number, v or Town, State)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number	e time, date and place, and due to the cause(s)
RES 000	29d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAMS QUAZI GOOD SAMARITAN HOSPITAL 5601 Lochravi State Registrar 31. Date filed (Month, Day, Year) FER 0 4 2008	1 29 2008

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Richard Lorenzo Sembly, Jr. 2008 10:41A M Jan. 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5220 York Road Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Hours **1** 2 □ F 64 Director 213-46-2210 1943 Maryland Apr. 30, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Na dical Examiner must be notified at 10c. City. Town or Location 10a. State 10b. County TYYes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5220 York Road Apt. J8 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Filter Rite Warehouseman Year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard L. Sembly, Sr. ပ Frances Minor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 0 5 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is any Injury or other trau once. Latasha Beale/ Daughter 721 N. Luzerne Ave Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 1/28/08 Baltimore, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Juneral Service Life yee Truis 5240 Reisterstown Rd Baltimore, Md 21215 art1. Enter the hock, or heart disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Immediate Cause (Final Physician EKU OVONAR resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine The law requires that the death certificate be executed physician an Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other-significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by EART 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown RRILLATIO 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe certificate ha death? 1 ☐ Yes 2 🗆 No 1□ Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: Natural 5 Pending Injury 1 TYes 2 TNo investigation 2 Accident the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D completely filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 着 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year 32 Registrar's Signature State Registrar 2008 FEB 04

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31. Date filed (Month, Day, Year)

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Registrar

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JANUARY 29 2008

		1 - State Registrar		Ce	ertificate of	Death		Reg. No.	2008	02831
Physi	cian	1. Decedent's Name (First, Middle,	Last) MARTHA \	/IRGINIA	STEM	-	2. Date of I	Death Day	Year	3. Time of Death 12:30 A M
/Med		4a. Facility Name (If not institution,			4b. City, Town,	or Location of	FEB.		1, 2008 12:30	
Exam	mer	CARROLL HOSP		OUSE		IINSTE			RROLL	
Funera Directo		5. Social Security Number 214 – 28 – 1085		(In yrs. last birthda) 76 Yrs.	Months Days			oay, Year) 11931	9. Birthp Cour MAR	place (State or Foreign ptry) LAND
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	Location				1	Od. Inside City Limits
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tth with to	ral Dire	10e. Street and Number 237 HOOK RD.			10f. Zip Code 211			US	n of What Coul SA	ntry?
IOTE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	ver in U.S. 13	l. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🛣 No		gin? (Specify Yes or t , Puerto Rican, etc.)		Race - Americ Black, White, pecify: WH	etc.
Maryland 21215-0036 nd 2 should be filed within 72 hours af tilth and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Examir traumatic event, the Medical Examir.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5-	(Giv	edent's Usual Occu re kind of work done DO NOT use retire	during most ed)	of working	Ī	of Business/In	dustry
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Baltimore, Dermit. Pages 1 an Department of Heal mportant: if Item 2 any injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			ematory or other pla	41	/4/08 DENS		tion - City or To	
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		23a. Part1. Enter the disease, or conshock, or heart failure. List of	omplications that caused				·		31(7 112	Approximate Interval Between
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IS, P.O. BOX res that the death ce igned by the attendi be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at 9 □ Unknown	Fetal death 3	☐Ectopic pregnand ☐Other (specify)	су		23d	d. Date of delive Month	ery Day Year
Records, P.O. Bc The law requires that the death ate has been signed by the atter age 2 should be detached for u.	by	Part II. Other significant condition	s contributing to death bu	t not resulting in the	underlying cause gi	iven in Part I.				he cause of death?
COrd w require been si	eted						9.20	_		
Vital Records, sician: The law requires t certificate has been signe irrector, page 2 should be or	Completed						24a. Wa au pe 1∐ Yes	topsy rformed?	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available mpletion of cause of 2 No
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Division or Vital Reform the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ht completely filled in by the funeral director, page	Certifi	4 ☐ Homicide determin	building, etc				City or 1	own, State)		al Route Number,
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•		30. Name and address of person w	11		e, Print)					
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S Regis	tate trar	31. Date filed (Month, Day, Year)	The Hegistra	r's Signature	71/30		V		TAYN TITE	, 110 2113
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene amend_#8 Per Inf G876 2/229egifinate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician Hutao Shan** Feb 1, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice Center Towson 8. Date of Birth (Month, Day, Jan 05 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** , *Bay*, *Y*, 05 Months Days Hours Min. Director 75 220-59-3437 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director MD Howard **Ellicott City** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21042 13306 Royden Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) + **Professor** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Feng Li ၉ Fengming Shan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. 13306 Royden Ct. Ellicott City, MD 21042 Jie Shan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Decremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb 04, 2008 Sykesville, Maryland All County Cremation Services, Sunature of lineral Service Licerses 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 limitelle MO0331 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. mediate Cause (Finst **Physician** STATE resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to [or as a conse]uence of Examine The law requires that the death certificate be executed physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical as attending I IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the detached 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 X No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 MOther (Specify) NOSPICE 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

7:52 A^M

China

2 No

Baltimore

U.S.A

Chinese

Education

Black, White, etc.

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

years

1 Yes

Division or Vital To the Hospital or Attending Physician; in by the funeral within 24 hours after death. To the Funeral Director: After completely

Records,

by

Completed

Be

2

Certification:

Medical

has page 2

certificate

this

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

25. Was case referred to medical examiner?

1 Tyes

27. Manner of eath

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and little of certifier

3 ☐ Suicide

29a. Certifier

2 No

5 ☐ Pending investigation

6 Could not be determined

J. CHARLES no 32. Registrar's Signature 0 4 FEB

6701

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

1 Inpatient

(Month, Day Year)

28a. Date of Injury

3□ DOA

28c. Injury at Work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29c. License number 0 48303

Charces ST

Registrar

			1 - For State Registrar Amend #30 perD'	State of Ma					Mental Hy	giene (08	02833
			Decedent's Name (First, Middle, Last)	11, 80,0, =	7 17 00 11				2. Date of De	ath		3. Time of Death
10	Physici	_	John J. Serafina						Janua	ry 30,	200	8 1040 p ^M
	/Medic		4a. Facility Name (If not institution, give s			4b.	City, Town, or	Location of Dea			ty ol Death	φ 10-20 β
F	Examin	er						_				MT 7
4.		K G A	National Lutheran F 5. Social Security Number 6. Sex		(In yrs. last bi		OCKV11 Inder 1 Year	If Under 24 Hr	s. 8. Date of Bi	rth	tgome:	L <u>y</u> blace (State or Foreign htry)
	Funeral Director	1		M 2 F	85		nths Days	Hours Mi		ay, Year)		vland
- 50	· *		Usual Residence of Decedent		0.5				04/25	11922	Mar	YIGHT
	land ow		10a. State 10b. County		10c. City, Tow	m or Location	1				1	I 0d. Inside City Limits
	Man,	ţō	Maryland Montgome	N 7	Boyd							1 ☐ Yes 2 No
	28a	Director	10e. Street and Number	<u> y</u>	1.Oycı	10	f. Zip Code		T I	10g. Citizen o	of What Coul	ntry?
	3a or	<u>a</u>	20622 Topridge Road	1		-	1841			United	State	20
	The 2	era		2. Was Decedent I	Ever in U.S.	13. Was I	Decedent of H	ispanic Origin?	(Specify Yes or N	o- 14. R	ace - Americ	can Indian,
10	hours after death with the Maryland tursi; or Iteme 23e or 28e-f ehow al Exacting must be notified at	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐X	ło			ın, Mexican, Pue	erto Rican, etc.)		lack, White,	
3	urs a	þ	3 XVidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 U Y	es XI No	Specify:		Spec	ity: Wh:	ite
21215-0036	n 72 hours after death with the Marylar "natural", or Iteme 23a or 28a-f ehow sales Examinar must be notified at	Completed	15. Decedent's Educ		16a	. Decedent's	Usual Occup	ation	in dila a	16b. Kind of	Business/In	dustry
215	within 7 ene. then "n	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO N	OT use retired	during most of w	ronking			
21	73 75 75	E O	10	CONCOCO (1 TOLO	S	teel W	lorker			Steel		
	Hygi other	Be C	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle	, Maiden Sum	ame)	
ä	ould be Mental Marked c	To B	Michael Serafinas					Mary Z	elinski			
Maryland	s 1 and 2 should be filled Health and Mental Hyg tem 27 is marked othe other treumatic event,		19a. Informant's Name/Relationship (Typ	oe, Print)	191	b. Mailing Ad	dress (Street	and Number or	Rural Route Numb	per, City or Tow	m, State, Zip	Code)
	27 is		Michael Serafinas -	- Son	2	0622 1	oprido	e Road	Boyd, Ma	ryland	21841	
ē,	Health tem 27 other tr	100	20a. Method of Disposition		20b. Place of	of Disposition	(Name of	2 III	Date	20c. Locatio		own, State
no	8 O L L	10	1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			or other place	02	/02/2008	Baltim	ore l	Marvland
Baltimore,	permit. Pag Department mportant: I iny njury o		21. Signature of Funeral Service License	10 _	Cen	etery 22. Nat	ne and Addre					ar y raiki
Ba	permit. Pag Department Important: I any njury o		Physic V	A		Davi	d J. W	eber Fu	neral Ho	mes P.A	Marri	land 21229
			23a. Rant. Enter the disease, or compli	cations that caused	the death Do						ricit y	Approximate
			shock, or heart lailure. List only on				m .4	2	1 .			Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Co	rond	ry (lut	ery L	Usean	l		years
1	/Medical Examiner		Toolang in coain,	Duento (or as	a consequence	ol):/	1 .	10.	1.	.7	7	house
н	×.	_	Sequentially list conditions, b	Jele	elex.	Isch	emi	clar	accome	10 Dal	hy .	years.
	bei ist	ine	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of);					1	a Also	00.0	1600000
	cate be executed oblysician and the burial-transit	Examin	that initiated events resulting in death) Last	Dun to (or as	a consequence	W/51 V	VCFIV	re prie	moriai	y cus	ease	years
90,	oe ex cian			Due to (or as	a consequence	olj.		/		/		/
8760	8 C E	dicai	_ d									
9		Mec	IF FEMALE:		USI 55%							
Вох	ath co	Physician/Me	23b. Was decedent pregnant in the past 12 months2	3c. If yes, outcome 1□Live birth	2 Fetal deat	h 3 Ecto	pic pregnancy	/			Date of deliv Month	rery Day Year
	e de a	Sici	1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 🗌 Oth	er (specify) _					
P.0	that the de led by the a detached i	h.	9 Unknown									
	8 6 9	þ	Part II. Other significant conditions con	tributing to death b	ut not resulting	in the underl	ying cause giv	en in Part I.				the cause of death?
Records,	w require been si should I								- 1	Yes 2□Ne	3 Pro	bably 4 Unknown
SC	law relas be	Completed							24a. Wa	s an 24	b. Were aut	opsy findings available ompletion of cause of
æ	The l	E							per 1 ☐ Yes	formed?	death?	2 No
Vital		0	25. Was case referred to medical					26. Place of E	Death (Check only			
5	Physician: this certific ral director,	0 8	examiner?	lospital:	ent 2 ER/C	Outpatient 3	DOA Ott	000	Home 5 ☐ Re		Other (Spec	ifv)
ō		늗	27. Manner of Death	28a. Date of Inju	ry 28b.	. Time of	28c. Injui			how injury oc		
0	th:	를	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y rear)	Injury		Yes 2 □ No				
Division	Attending or death.	flea	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inj	ury - At home,	farm, street,	actory, office				ımber or Rui	ral Route Number,
Ö	ai or Attend after death I Director: , d in by the f	Certification:	4 Homicide	building, et	c. (Specify)				City or T	own, State)		
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 ertifying Phys	sician: To the best	of my knowledd	ge, death occ	urred at the til	me, date and pla	ace, and due to th	e cause(s) and	manner as	stated.
	24 r 24 r 6 Fui	Medicai	(Check only 2 Medical Examination)		f examination a							
-	o th o th ompl	Me	29b. Signat re end title of certifier	1			29c. Licens	se number		29d. Date sig	ned (Month	, Day, Year)
	4.		> Vando	11/6	101-		102	4721	,	Ana.	1000	2/ 1000
	24		30. Name and address of person who co	moleted cause of	leath (Itam 22a) (Tuno Brim	100	1176	,	you	reerse,	31,2008
	1					, (iype, riin))		V		6	
	8 6	oto	Charles Karesh, MD Nat			R DF	E					
	St Regist	ate	EED 0 4 2008	And and	A. A.	food.						

			For State Registrar	State of I	Maryland		artment o			nd Me		giene,	008	0	28	34
	Physici		1. Decedent's Name (First, Midd	lle, Last) Sellman	Co				-		2. Date of Dea Month		Year		Time of C	Death M
	/Medic Examir		4a. Facility Name (If not institution	on, give street and number	ər)		4b. City, To	9			01		ounty of Dea			,
	•		Ken Singt 5. Social Security Number	6. Sex 7.	ng Ho		If Under 1		Sing If Under 2	1			1 ont			
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	land land		Usual Residence of Decedent 10a. State 10b. County	/	10c. City	, Town or Lo	cation							10d. In	side City	y Limits
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980	hours after lurel', or ite	by	1 Never Married 2 Mai	If Yes Give	No No		fYes, specify 1 □ Yes 2X		Mexican, Specify:	Puerto F	lican, etc.)		Black, Whi pecify: b1			
21215-0036	ithin 72 ho ie. ien "netur Madical	Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-40	or 5+)	(Give	tent's Usual (kind of work of DO NOT use	done du	ion ring most	of workin	g unk	16b. Kind	of Business	/Industry	ι	unk
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Maryland	nd 2 should th and Me 27 is mark treumation	T	19a. Informant's Name/Relation: Kensington N				-				Route Numbe			Zip Code	.)	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or items 23a or 28a-f show any injury or other treumatic event, the Madical Examiner must be notified at once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 ★ Other (3)	3 □Removal from Sta	te ce	ace of Dispo	sition (Name natory or othe	of	Ţ		ate		ation - City or	Town, S	tate	
Balti	permit. Departm Importer any inju	Ì	21. Signature of Funeral Service		rector		Name and A ate Ar		12.00	ard 21201	655 W.	Balt	imore	Stre	eet	
	23a. Part Enter the disease, of complications that caused the death. Do not shock or heart failure. List only one cause on each line. Physician /Medical- Examiner 23a. Part Enter the disease, of complications that caused the death. Do not shock or condition as a consequence of the complex							of dying,		ardiac or	respiratory and	rest,		Inten	roximate val Betw et and D r K u t	eath
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	as a consequ	ence of):										
8760,	le be execu /sician and e burial-trar	dicai Exa	resulting in death) Last	Due to (ar	as a consequ	ence of):			,							
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rds, P	w requires that been signed I should be det		Part II. Other significant condition Dys pwagi	a, G.	tube	feed		se given	in Part I.			bacco use	o contribute t	o the cau robably		eath? nknown
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Vital	Physicien: The I this certificate ha	Be	25. Was case referred to medica examiner?	Hospital:					4		(Check only or					
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ion	ending l sath. or: After he funer	ation	E	igation	Day Year)	Injury	М	Work? 1 ☐ Ye	s 2□N	lo						
Division	l or Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 289. Place of	Injury - At hore etc. (Specify,	me, farm, str)	eet, factory, o	ffice		2	Bf. Location (S City or Tow		Number or A	ural Rout	te Numb	oer,
	To the Mospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	edical C	29a. Certifier 1/2 Certifyi (Check only one) Medical	ng Physician: To the be Examiner: On the basis and manner	of examinati	vledge, death ion and/or in	occurred at vestigation, in	the time, my opin	, date and nion, death	place, ai	nd due to the o	cause(s) a date and p	nd manner a lace, and du	s stated. e to the c	:ause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifie	adly			29c. L	icense r	number 3/2/	,	2	29d. Date	signed (Mon	th, Day,)	rear)	
			30. Name and address of person NURYL CHOIN 31. Date filed (Month, Day, Year	who empleted cause of	f death (Item	23a) (Type, 2/6 D	Print)	rive	16	urto	nsvil	le , 1	MDZ	081	66	
* K	Sta Registr		31. Date filed (Month, Day, Year FEB 0 4	32 Aegi	strar's Signat	ure	and o									

			1 - State of Maryla		artment of rtificate of			Reg. No	008	02835	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) William R. Schwartz Jr				2. Date of D Month Januar		200 ^{Year}	3. Time of Death 5:00 PM M	
)	Examir		4a. Facility Name (If not institution, give street and number) 10012 Shanktown Road		4b. City, Town, Big P	or Location of De	ath		4c. County of Death Washington		
	Funeral Director		218-44-5261 ¹ ♥ ¹ ♥ ² □ F 60	s. last birthday) Yrs.	If Under 1 Yea Months Day			irth la <i>y, Year)</i> • 1947	9. Birth Cou Mar	place (State or Foreign Intry) yland	
	Maryland -f ehow	tor	Usual Residence of Decedent	City, Town or Lo	Pool					10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	sa or 28a	Il Direc	10e. Street and Number 10012 Shanktown Road	2-8	10f. Zip Code	21711		10g. Citize	on of What Cou USA	-	
980	within 72 hours after death with the Maryland ane. then "naturel", or Items 23e or 28e-f ehow he Medical Exeminer is ust be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 X Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 N	f Hispanic Origin? uban, Mexican, Pu lo Specity:	(Specify Yes or Nerto Rican, etc.)		Race - Amer Black, White Specify: Wh	, etc.	
21215-0036	within 72 houlene. then "naturelle Medical E	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0	(Give	dent's Usual Occ kind of work don DO NOT use reti careta	ne during most of (red)	working	16b. Kind	of Business/l	ndustry unk	
Maryland 2	nould be filed I Mental Hygi narked other natic event, I	To Be Co	17. Father's Name (First, Middle, Last) William Royston Schwartz	10h Maiti	18. Mother's Name (First, Middle, M Virginia Agnes 1			s Bosl	ey	in Code)	
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Important: if Item 27 le marked other then "naturel", or Items 23a or 28a-f show mary Injury or other traumatic event, the Madical Examiner must be notified at Once.		19a. Informant's Name/Relationship (Type, Print) Michelle Carr/niece 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☒ Donation 5 □ Other (Specify)	100		ktown Ro		001, M		11	
Balti	permit. Depertrainmports eny Inju-		21. Signalure of Funeral Service Licensee Ronald S. Wade, Directo	or St Ba	Ale And altimore	tomy aboa,	rd 655 W 201	. Balt	imore :	Street	
	Physician /Medical Examiner properties on properties on properties of properties of the properties of	Examiner	23a. Pakt. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Immediate Sause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consideration of the cause. Consideration of the cause of	equence of):	eer the mode of d	lying, such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Death	
P.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physicien end bage 2 should be detached for use as the buriat-transit	Completed by Physician/Medical I	d	stal death 3	⊒Ectopic pregnai ⊇Other (specify)			23	3d. Date of deli Month	very Day Year	
	w requires that been signed by should be deta	ed by Pr	Part II. Other significant conditions contributing to death but not refer to the significant conditions.	esulting in the u	inderlying cause	given in Part I.		d tobacco us]Yes 2□		the cause of death?	
al Reco		Complet	Deptession be condi	troning				topsy formed?	24b. Were au prior to death?	topsy findings available completion of cause of	
Division of Vital Records,	To the Hospital or Attending Physicien: The within 24 hours effer death. To the Funeral Director: Affer this certificete completely filled in by the funeral director, pag	tlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 27. Manner of Death (Month, Day Year) 2 Accident investigation		of 28c. Ir	Other	Death (Check only g Home 5 ☐ Re 28d. Describ	sidence 6	-	Mayber sodA (Mic	
Divisi	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affer completely filled in by the fune	Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - Al building, etc. (Spe	t home, tarm, st cify)	reet, factory, offic	СӨ	28f. Location City or 1	(Street and own, State)	Number or Ru	ıral Route Number,	
	the Hospl nin 24 hou the Funar npletely fill	ledical	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my leaders of examiner: On the basis of examiner and manner stated.	nowledge, deal ination and/or in	nvestigation, in m	y opinion, death o	ace, and due to the courred at the time	e, date and p	place, and due	to the cause(s)	
	To To Con	2	29b. Signature and title of certifier Primary Primary	Care physi	icies 1	oo 6 3363		230. Date	Signed (Monti	, Jay, 1841/	
	St	ate	30. Name and address of persen who completed cause of death (I DO NG HYUN LEC, M.s., GL 31. Date filed (Month, Day, Year) 32. Registrar's Signary	2 Seto	Print)	Cumbert	and, N	10 2	207		

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Baltimore,

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician JOUR lava 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Medical Center Battimore University of If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 782 1 □ M 2 🕅 F 244-48-7829 Usual Residence of Decedent North Director Carolina permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 ☐ No Funeral Directo more 10f. Zip Code 10g. Citizen of What Country 10e Street and Number Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify þ Specify. Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Westinghous 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wonter ٩ MK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Husband) 8 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 FiRemoval from State 2008 4 Donation 5 Dother (Specify) Son 22. Name and Address of Facility JOSEPH L. RUS 2222 W. North 21. Signature of Funeral Service Lipensee of LiRuss Funeral Home, P. W. North Ave Balto Md 2 23a. Part1 in er the diser shoc or heart failu v Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e, or complications that caused List only one cause on each line Cardiac Arrythmia Physician min disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal Disease 2 No Transplant 3 Probably 4 ☐Unknown 1 ☐ Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hypertension After this certificate has page 2 2□No or Attending Physician: funeral director. 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) in

Registrar

State

31. Date filed (Month, Day, Year)

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4 2008

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Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

08-00893 James C. Walter

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State of Maryland	Department at He	and Mei	ntal Hydlene

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Physician/ polical Examiner James Courtney Walter 4a. Facility Name (if not insitution, give street and number) 116 Mike Court 116 Mike Court 116 Mike Court Funeral Director Funeral Director Funeral Director To Social Security Number 116 Mike Court 117 Age (in yrs. last birinday) 118 Months Days Hours Min. 06/16/1981 119 Cecil 110 Age (in yrs. last birinday) 110 Months Days Hours Min. 06/16/1981 110 Age (in yrs. last birinday) 110 Months Days Hours Min. 06/16/1981 110 Age (in yrs. last birinday) 110 Months Days Hours Min. 06/16/1981 110 Age (in yrs. last birinday) 110 Months Days Hours Min. 06/16/1981 110 Age (in yrs. last birinday) 110 Months Days Hours Min. 06/16/1981 110 Age (in yrs. last birinday) 110 Months Days Hours Min. 06/16/1981 110 Age (in yrs. last birinday) 110 Months Days Hours Min. 06/16/1981 110 Age (in yrs. last birinday) 110 Months Days Hours Min. 06/16/1981 110 Age (in yrs. last birinday) 110 Months Days Hours Min. 06/16/1981 110 Age (in yrs. last birinday) 110 Months Days Hours Min. 06/16/1981 110 Age (in yrs. last birinday) 110 Months Days Hours Min. 06/16/1981 110 Age (in yrs. last birinday) 110 Months Days Hours Min. 06/16/1981 110 Age (in yrs. last birinday) 110 Months Days Hours Min. 06/16/1981 110 Age (in yrs. last birinday) 110 Months Days Hours Min. 06/16/1981 110 Age (in yrs. last birinday) 110 Age (in yrs. last birinday) 110 Months Days Min. 06/16/1981 110 Age (in yrs. last birinday) 11	d. Inside City Limits Yes 2 X No ? In Indian, Black, ite ustry e
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### Page of the pa	d. Inside City Limits Yes 2 X No ? In Indian, Black, ite ustry e
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Sequentially list conditions, Due to (or as a consequence of):	
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123d. Date of delivery 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery Month Date	ay Year
past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
23b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown 23b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown Part II. Dther significant conditions Contributing to death but not resulting in the underlying cause given in Part I. 23c. Did tobacco use contribute to the past 12 months?	he cause of death?
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24a. Was an autopsy performed?	ompletion of cause of
Yes 2 ✓ No 3 Probe 2 of Place of Death (Check only one)	s 2 No
25. Was case referred to medical examiner? Hospital: 1 Innatient 2 FR/Outpatient 3 DDA Other; Nursing Home 5 Residence 6 Other;	: Scene
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28d. Date of Injury (Month, Day, Year) 27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	
Natural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be determined determined (Specific) (Specific) 2 See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rur or Town, State)	ral Route Number, City
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29a Certifier . To the heat of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as state	ed.
Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. 29d. Date signed (Mor	
S 29b. Signature and title of certifier	
Kayone The Grill	· ————————
30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Margarian Signature	
State 31. Date filed (Month, Day, Year) Registrar FFB 0 4 2003	
DHMH 17 Rev 1/2001 ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year 16:3Z PM Ruth Virginia Younkins 2008 tebuary 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ballimore Agnes Hospital n/a If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F 213-36-7310 68 8/29/1939 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits n/a 1 XYes 2 ☐ No MD Baltimore Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2441 Ashton Street 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2K No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: white 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Supervisor Medical Supply 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leon W. Younkins, Sr. Helen Yeatts Hoover 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria L. Bentley / Dau. 2441 Ashton St., Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 2/6/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Right basal ganglia one day disease or condition resulting in death) Due to (or as a consequence of) Frontal lobe if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events pressure High blood resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕱 No 3 □ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 N nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

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"natural", or items 23a

permit. Pages 1 and 2 should be filed within 72 ht. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Box 68760,

P.O. I

Division or Vital Records,

or Attending Physician:

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The law requires that the death certificate be executed and the attending page 2 s has certificate

Physician/Medical Completed by Be Medical Certification: To after death.

I Director: Af
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28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

31. Date filed (Month.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number 20966 29d, Date signed (Month, Day, Year) tebuary 2006

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bultimore s. Caton

21229

within 24 hours aft To the Funeral DI completely filled in

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Zahlis Month 8 M **Physician** 2008 10 MINIC Tanuar. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimure ohns HOPKINS HOSPITAI If Under 1 Year | If Under 24 Hrs. 6. Sa 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday, **Funeral** Months Days Hours 1⊠M 2□F California Aug 11, 1997 10 Director 620-98-7228 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Director Columbia MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 9503 Gray Mouse Way 21046 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Δ Student Elementary School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christopher John Zahlis ANdrea Marie Poulos ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9503 Gray Mouse Way, Columbia, Maryland 21046 Christopher J. Zahlis /father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or 4 □ Donation 5 □ Other (Specify) Union Cemetery Jan 31, 08 Burtonsville, Maryland 21. Signature of Funeral Service Lice is 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 M00773 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Carre (Final disease or condition resulting in death) brain Stem **Physician** Q VR days /Medical Due to (or as a consequence of): Examiner Onset Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): <u>la</u> that the death certificate be executed Exami burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician at the burial Physician/Medical as attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ★ No 24a. Was an cate has l certificate 1□ Yes 2**∑**™o the Hospital or Attending Physician: 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA ို After this funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐Pending investigation Natural 2 Accident Injury the Funeral Director: After anietely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melson Wolte Street Baltimore Mary land 21287 600 north Isten Registrar's Signature 31. Date filed (Month, Day, Year State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year ZEMLYANSKY GRIGORIY 31, 2008 January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/21/1928 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Days Hours UKRAINE 79 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2 No BALTIMORE BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2201 WOODBOX LANE 21209 UKRAINE 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MANAGER MANUFACTURING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CEILIA CHANA ZEMLYANSKY SHMUEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRINA KRAVETS / DAUGHTER 2201 WOODBOX LANE, BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW 02/01/2008 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Solet 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HEPATIC ENCEPHALOPATHY Due to (or as a consequence of): CIRRHOSIS Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HEPATITS C Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown

Physician /Medical **Examiner**

burial-transit

for use as the

sate has been signed by the a page 2 should be detached it

funeral director,

physician

Box 68760

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Division or Vital Records,

or Attending

Hospital

24 hours after death e Funeral Director:

To the

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at

Baltimore, Maryland 21215-0036

Physician/Medical

Completed

Be

Certification: To

2

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23e. Did tobacco use contribute to the cause of death?

2 No

3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 26. Place of Death (Check only one)

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

5 ☐ Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 Suicide

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 🗌 Yes

29a. Certifier (Check only one)

4 Homicide

Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D0060687

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIBMC, 6701 N CHARLES ST, BALTIMORE MD PONY M THOMAS 31. Date filed (Month, Day, Year)

State Registrar

FEB 0 4 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For MEND#24a / openMD1 /25 / 08 , BW Maryland / Department of Health and Mental Hygiene Project Mental Project AMEND#7, 8, per INF1 / 23 / 08, BW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 102 /Medical BAUGI 15 2008 4a. Facilify Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 924 April 22 1922 **Funeral** 9. Birthplace (State or Foreign 1**∑** M 2□ F Director 142 16 1322 New Jersey Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits Director 1 □Yes 2 XINo Maryland Montgomery Bethesda 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 8102 Hampden Lane 20814 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, filed within 72 hours after (Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√XNo Specify. þ 3 ☐ Widowed 4 ☐ Divorced White WW II Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Manager Met Life Insurance Co is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental William Abraham Lillian Roth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau Carol Arlan / Wife 8102 Hampden Lane Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Paurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gdn of Rememberance 1/18/2008 Clarksburg, Maryland 21. Signature of Funeral Service Vicense 22. Name and Address of Facility Hines Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, MD20904 23a Part1. E fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm siate use (Final disease or condition resulting in death) Sepsis Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last REUMONIC Examiner Due to (or as a consequence of the death certificate be executed physician and s the burial-trans Urina Int Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as nse IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ò in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Ves 2 No 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an this certificate has autopsy performed? Yes 2 No page 1∐ Yes or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes _ 2 No P ER/Outpatient 1 Inpatient 3 □ DOA funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury after death.

I Director: A
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) *DOO642*3< 7008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (3) 9901 Medical Center Dr., Rockville, MD 20850 31. Date filed (Month 18 32. Paistrar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

08-00627 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James Anasiewicz State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day January 22, 2008 James Phillip Anasiewicz Medical Examiner 1737 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 209 Meadow Gate Terrace Gaithersburg Montgomery 5. Social Security Number 9. Birthplace (State or If Under 1 Year I If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 7. Age (In vrs. last birthday) **Funeral** Director 284-50-8576 Months Days Hours Country Ohio 1X M 2 58 August 11,194 Yrs Usual Residence of Decedent any 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1XX Yes 2 No s 23a or 28a-f show e notified at once. 28a-f show Gaithersburg Marvland Montgomery Director 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 209 Meadowgate Terrace 20877 United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican. etc.) White, etc. 1 X Never Married 2 Married Yes 2 X No item 27 is marked other than "natural", it traunatic event, the Medical Examiner. Widowed Divorce Yes, Give Year Specify: Caucasian Yes 2 No specify: ş 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16h Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Pages I and 2 should be filed within 72 I rent of Health and Mental Hygiene. MD 21215-0036 5+ Attorney Lega1 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Leo Anasiewicz 19a. Informant's Name/Relationship (Type, Print) Stella Novak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leona Anasiewicz-Sister 209 Meadowgate Terrace, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Date 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State mportant: Linjur. Fort Lincoln Crematory 1-30-2008 Brentwood, MD Other Specify Donation 5 22. Name and Address of Facility Simple Tribute
1040 Rockville Pike, Rockville, MD 20852 Signature of Funeral Service License 21 **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Sertraline, alprazolam, and alcohol intoxication immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical XUNPENDED AMENDED. #23a.27.28a-f. perME.g876. 2/14/08 TT e attending physician for use as the burial The law requires that the death certificate be P.O. Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the s been signed by the attending should be detached for use and Live birth Ectopic pregnancy Dav Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed? death? ✓ Yes 2 No. 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: Other ER/Outpatient DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Yes 2 X No Pending subject ingested drugs and alcohol Fnd 1/22/2008 Fnd 5:30 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Suicide Could not be 209 Meadow Gate Ter. Gaithersburg, M (Specify) Found; residence Homicide 29a. Certifier 1

State Registrar DHMH 17 Rev 1/2001

OCME 2006

Medical

29b. Signature and title of certifie

Ling Li, MD

31. Date filed (Month, J

and manner stated

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

2008

Assistant Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 23, 2008

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ARN Registr

Division or Vital Records, P.O. Box 68760,

	1 - For State Registrar	Certificate of Death	Reg. No. 2008 02044
	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year 3. Time of Death
an al	Thelma E. Anderson	l. ₃	January 12 2008 2:05 a
er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Millennium @ South River	Edgewater	Anne Arundel
	5. Social Security Number 6. Sex 7. Age (In yrs. last	Months Days Hours Min	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
	217-12-1795 1DM 25F 84	Yrs	Aug. 6 1923 Maryland
	Usual Residence of Decedent	own or Location	10d. Inside City Limits
_	Tod. State	own or Essential	1 ∑Yes 2 No
ctc	Maryland Anne Arundel Harw		
Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
ra	4650 Sands Road	20776	USA
m	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- lican, etc.) 14. Race - American Indian, Black, White, etc.
Ϋ́F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2万 No If Yes, Give 1 ☐ Yes 2万 No If Yes, Give 2 ☐ Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	Specify: Black
Completed by	A	6a. Decedent's Usual Occupation	16b. Kind of Business/Industry
lete	(Specify only highest grade completed)	(Give kind of work done during most of working life. DO NOT use retired)	g
Ĕ	Elementary/Secondary (0-12) College (1-4or 5+) 12th 0	Transportation	South County
ŭ	17. Father's Name (First, Middle, Last)	*	Health Center (First, Middle, Maiden Surname)
o Be	John F. Chapman	Holon	L. Hill
은		9b. Mailing Address (Street and Number or Rural	· · · · · · · · · · · · · · · · · · ·
1 3	Helen E. Anderson (Daughter)	4650 Sands Rd. Ha	
5			ate 20c. Location - City or Town, State
	14⊾Burial 2 ∐Cremation 3 ∐Hemoval from State		/00 Dm:: Wd
	21. Signature of Funeral Service Licensee	es Cemetery 1/19/ 22. Name and Address of Facility	08 Drury, Md.
	Farm M. Rees MO0483	Wm. Reese & Sons	
	23a. art1. Enter the disease, o complications that caused the death. D	821 West St. Anna	respiratory arrest, Approximate Interval Between
	shock, or heart failure. List only one cause on each line.	L . 11	Interval Between Onset and Death
	disease or condition resulting in death)	nry mia	
	Due to (or as a consequence	e or):	
e	Sequentially list conditions, if any lead of the conditions of the	ce of):	
m in	Cause (Disease or injury		
Exa	that initiated events resulting in death) Last C Due to (or as a consequence	ce of):	
Medical Examiner	d		
edi			
<u></u>	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy		23d. Date of delivery
Completed by Physician/I	in the past 12 months? 1 Very 2 Physics 4 Pregnant at time of death		Month Day Year
hys	9 Unknown		
γP	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
q pe	Old Cerebrovesous	al Decere	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown
lete	Dec leter Molitics		24a. Was an 24b. Were autopsy findings available
шс	7,00000		autopsy prior to completion of cause of death? 1
Ö	25. Was case referred to medical	26. Place of Death	
o Be	examiner?	Outpatient 3 DOA Other: 4 Unising Hom	
Ë	27. Manner Death 28a. Date of Injury 28	b. Time of 28c. Injury at 2	8d. Describe how injury occurred
tio	1 latural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury Work? M 1 Yes 2 No	
Hice	3 Suicide 6 Could not be determined 28e. Place of injury - At home,	, farm, street, factory, office	8f. Location (Street and Number or Rural Route Number,
ert	4 Hornicide determined building, etc. (Specify)		City or Town, State)
Medical Certification: To	29a. Certifier 1 Certifying Physician: To the best of my knowled		
edic	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occurre	ed at the time, date and place, and due to the cause(s)
Me	29b. Signature and title of contifier	29c. License number	29d. Date signed (Month, Day, Year)
		757028	01-15-08
	30. Name and address of person who completed cause of death (Item 23		
	Aditua Chopra M.D. (00	00 Bidgely Ave. #2	231 Annapolis MD 21401
te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
ar	JAN 1 6 2008 Streve B	Loule	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Chester Arthur Briggs January 15, 2008 7:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ginger Cove Health Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min 305-42-7536 Hours 94 Director May 29, 1913 Indiana Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location show 10d, Inside City Limits r 28a-f show notified at Maryland Anne Arundel Annapolis 1 ☐ Yes 2XXXIVo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 4238 River Crescent Drive 21401 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or ite tydyes 2 □ No If Yes, Give Year or Dates: 1931–1958 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ White 3XXVidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Captain U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chester Calvin Briggs 0 Laura Karst 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Candalor/daughter 8227 Running Creek Ct. Springfield, VA permit. Pages 1 ar Department of Hea Important: If Item : any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial

Cremation 3 ☐ Removal from State Baltimore Crematory 1/17/2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Hxpertension, malignant 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s Dementiq 1□ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural after death. 1 TYes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. D 0029571 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Defense Hmy, Crofton, mo 2/114 Gleen & Speck Registrar

DHMH 17 Rev 1/2001

rilliam Bradley	State of Maryland / 1- For State Registrar	Certificate of	Health and Mental F Death		9. No. 2008	02846
Physician				Date of Death Month		3. Time of Death 1128 hrs
ledical Examine	William Clayton Bradley 4a. Facility Name (if not institution, give street and number)	14	b. City, Town, or Location of Deat	January 26	4c. County of Death	1126 NFS
	300 Byrn Street		Cambridge		Dorchester	
Funeral Director	5. Social Security Number 6. Sex 7. Age 1 X M 2 F	(In yrs. last birthday) 16 Yrs.	If Under 1 Year If Under 24Hr Months Days Hours Min		h(MM/DD/YYYY) 9. Birt Foreig 1991 Cou	hplace (State or n ^{Intry)} Maryland
any	Usual Residence of Decedent 10a. State 10b. County 1	0c. City, Town or Location				10d. Inside City Limits
* .	N- 1 1 D 1 - 1	Hurloc				1 X Yes 2 No
the Maryland a or 28a-f show tified at once.	10e. Street and Number	Harrock	10f. Zip Code	10	g. Citizen of What Cour	try?
ith the Maryland 23a or 28a-f sho notified at once			21643		USA	
r death with or items 23 nust be no	11. Marital Status 1 X Never Married 2 Married Armed Forces?	If Ye	Decedent of Hispanic Origin? (\$ es, specify Cuban, Mexican, Puert		14. Race - Ameri White, etc.	can Indian, Black,
		X No	Yes 2 X No specify:		Specify:	White
ours aft	15. Decedent's Education (Specify only highest grade comp		's Usual Occupation (Give kind of ost of working life. DO NOT use re		16b. Kind of Business/I	ndustry
5-0036 ed within 72 hour lygiene. other than "natu	Elementary/Secondary (0-12) College (1-4 or 5+	·)	•	(iieu)		1
5-0036 iled within 72 Hygiene. I other than the Medical	11 17. Father's Name (First, Middle, Last)	Stude		e (First, Middle, N	High Scho Maiden Surname)	01
21215-0036 21215-0036 Mental Hygiene. marked other than "e event, the Medical	Don William Bradley		Charlo	tte Lank	ford	
O 8 5 5 € L	T .		Address (Street and Number or			Zip Code)
ore, MD 2 ss I and 2 shou of Health and N If item 27 is n her traumatic	Don W. Bradley/Father 20a. Method of Disposition	20b. Place of Disposi	Box K, Hurlock tion (Name of cemetery,	Date Date	nd 21643 20c. Location - City or	Town, State
Baltimore, MI permit Pages I and 2 s Department of Italih a Important: I fiten 27 injury or other traums	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:		erplace) sington Cem. 1/3	30/2008	Hurlock, Ma	arvland
altin	4 Donation 5 Other Specify: 21. Signature of Funeral Sery/ce/cjcensee		ame and Address of Facility ller Funeral Ho st New Market,			<u> </u>
	23a. Part I. Enter the disease, or complications that caused the	Eas	st New Market,	m 21631	. BOX 207,	Approximate Interval
Physician /Medical	failure. List only one cause on each line.		e mode or dying, such as cardiac	or respiratory arre	est, shock, of fleat	Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Narcotic into Due to (or as a consection)					
<u>.</u>	Sequentially list conditions, b	auence of):				
led Insit	cause. Enter Underlying Cause (Ulscase or Injury that Initiated					
ecuted and transit		quence of):				
2. ਜ਼ੁਜ਼ੀ ਲੇ	X UNPENDED AMENDEBIT 27	28a-f porME	C877 3/10/08 TT			
760, icate be ex physician the burial	IF FEMALE: 23b. Was decedent pregnant in the	e of pregnancy			23d. Date of delivery	
Sox 6876 leath certificat e attending ph for use as the	past 12 months? 1 Live birth 4 Pregnant at ti	mo of dooth	al death 3Ectopic pregr ner (Specify)	ancy	Month [Pay Year
Box ne death of the attented for us	1 Yes 2 No 9 Unknown 9 Unknown					
P.O.		but not resulting in the u	nderlying cause given in Part I.	1	bacco use contribute to	
Records, The law require; ficate has been sig	ISUM			24a. Was a	an 24b. Were au	topsy findings available
of Vital Records, ing Physician: The law requires the this certificate has been sineral director, page 2 should by To Re Committee.				autop perfor 1 V Yes	med? death?	completion of cause of
			26.Place of Death (Chec		2 No 1 Ye	es 2 No
f Vital Physician or this cert ral directo	1 ✓ Yes 2 No Inpatien	t 2 🗸 ER/Outpatient			Residence 6 Other	
n of iding Plans. h. After funera	27. Manner of Death 28a. Date of Injury (Month, Day,Yei Pending Tod 1/26/	ar)	1 Vos 2V No	28d. Describe f	now injury occurred	
Division of Vital I is a fler ding Physicinu: The all or Attending Physicinu: The all Director: After this certification by the funeral director, artification: To Be of	2 Accident Pending Investigation 28e. Place of Inju		t, factory, office building, etc.	28f. Location (S	Street and Number or Ru	ral Route Number, City
	3 Suicide 6 X Could not be determined (Specify) ho	use	,, <u>3</u> ,	300° Byrn	^{tate)} Street Cambri	dge, MD
		knowledge, death occum		d due to the caus	e(s) and manner as stat	ed.
To the He within 24 To the Fr complete	one) 2 Medical Examiner: On the basis of examinand manner stated. 29b. Signature and title of certifier	ination and/or investigati	29c. License number	at the time, date	and place, and due to the	
	1/2/11 = A 2 4(= 22		O.C.M.E.		January 27, 200	
	30. Name and address of person who completed cause of de	ath (Item 23a)				
	Margarita Korell MD. Assistant Medical E	Examiner 111 Pe	enn Street, Baltimore, MD	21201		
State Registra	I IAN VII 2000 I III	s Signature				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Julian Blake 4:13 PM Kenneth 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Genter Kegional OMICO 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Year) 220-52-0524 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. I show the man 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at raumatic event, the Medical Examiner must be notified at Salisburg 1 Yes 2 No Director Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 Division Street USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ٥ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) rator Paving Contractor

18. Mother's Name (First, Middle, Maiden Surnahe) Operator 17. Father's Name (First, Middle, Last) Be Mathews HENry (!leo Blake James မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Department of Health a Important: If Item 27 is any injury or other trainonce. Cambridge, Maryland 2/6/3

20c. Location - City or Town, State Judith 40 Cakley Street Blake 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 126/08 Cambridge, Maryland Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee January Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) unknow pheumono /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Examiner executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): the death certificate be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ASCUD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1□ Yes Vital Physician: funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient Ö 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. Director: After Division 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 0 To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed [Month, Day, Year) D30853 18/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Charles B. Silvia James

31. Date filed (Month, Day, Year) JAN 22

DHMH 17 Rev 1/2001

gistrar's Signatur

Peninsula Regional Medical Center Salisbury uns 2190

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008	02848
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Dustin Elliott Bruch	1-	For State	late of Mi	ai yiai ia 7 c	Certi	ificate d	of Death	1	, ,0	Reg	J. No.		
Physician	1.	Decedent's Name (First, Mide							2.	Date of Death Month	Day 200		3. Time of Death 2239 hrs
Medical Examine		Dustin a. Facility Name (if not instituti	Ellio		Bru	ch	Ah City. T	own, or Location of		January 4,	4c. County		
	4	Penninsula Regional					Salisb				Wicomi		
Funeral	5	Social Security Number	6. Sex	7. Age (in yrs. las	t birthday)	If Unde	r 1 Year If Under	Min		(MM/DD/YYY)	Foreign	
Director	2	215-31-2148	1X M 2	F 17		Y	rs.	bays Hours	JVIII I.	12/12/	1990	CoM	Tyland
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the Maryland a or 28a-f sh tified at once		Maryland Wic	:OIIITCO		Del	LINGL	10f. Zip			10	g. Citizen of W	hat Count	ry?
ith the Maryland 23a or 28a-f show notified at once		8955 Bi-Stat	e Blvd	•				1875			USA		an Indian, Black,
> & a		Marital Status Never Married 2		Vas Decedent Ev rmed Forces?		5. 13. \ 1	Was Decede f Yes, specif	int of Hispanic Orig fy Cuban, Mexican	gin? (Spec , Puerto Ri	cify Yes or No- ican, etc.)		e - Americ te, etc.	an Indian, Black,
er deat	-1		livorced If Yes,	Give Year	No	1	Yes 2	X No specify:			Specify:	W	hite
urs aft tural"	∂⊨	15. Decedent's Education (Sp	or Date	es:	leted)	16a. Deced	dent's Usual	Occupation (Give rking life, DO NOT	kind of wo	rk done	16b. Kind of B	usiness/Ir	ndustry
6 72 ho nn "na cal Ex		Elementary/Secondary (0-12	2) Co	ollege (1-4 or 5+	·)		tudent	_		-,	 educat	ion	
003 within giene. her th	Completed	11 17. Father's Name (First, Midd	le Last)	<u> </u>	1		Ludent		's Name (l	First, Middle, N	Maiden Surnam		
21215-0036 build be filed within 7 Mental Hygiene. The warked other than the Medical	a B	Robert L. Br						Kay	Elli	ott			
212 rould b d Men s mar tic eve	<u>-</u>	19a. Informant's Name/Relatio		rint)				Street and Nur.					Zip Code)
MD and 2 sho alth and arm 27 is raumati	-	Kay Elliott/n	nother		20b. F	Place of Dis	position (Na	me of cemetery,	1 va. ,	Date	20c. Location	1 - City or	Town, State
Ore, ges la tof He : If ite		1 X Burial 2 Cremat	ion 3 Re	moval from Stat	م ا	rematory or	r other place	emetery	1/3	1/08	Powel	llvil	le, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland De, artment of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other tranmatic event, the Addical Examiner must be notified at once The Comment of the Comment	-	4 Donation 5 Other 21. Signature of Funeral Servi	Spedify: ce Licensee		l			- Address of Facility	<u>y</u>	Iomo Dr	ofessi.		Association
De Ban		1116h	10112	m cf	SP		501 S	inou Hill	Rd.	Salis	bliry.	4ロースエ	Association 804 Approximate Interval
Physician /Medical	1	23a. Part Enter the disease, failure. List only one cau	or complication	ns that caused to e.	he death.	Do not ent	er the mode	of dying, such as	cardiac or	respiratory arr	est, snock, or r	leart	Between Onset and Death
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60, ate be exphysician be burial.	Medical	UNPENDED IF FEMALE:	1 4	FNDED 2.perME. c. If yes, outcom			'08 TT /	/ 28a, perl	E,g8/	/ 3/12/0	23d. Date	of deliver	<u> </u>
x 6876 A certificat A certif	N/ug	23b. Was decedent pregnant in past 12 months?		Live birth		2	Fetal deat		ic pregnat	псу	Month	1	Day Year
Box 6876 Box etrifica The attending pheated for use as the	sician/		Unknown 9	Pregnant at t	time of de	eath 5	Other (Sp	ecify)					
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P.O. res that the signed by be detach	d b												utopsy findings available
Records, P The law requires 1 Troate has been sign page 2 should be 1	ete									24a. Was auto		prior to death?	completion of cause of
Records, The law requir	Completed				_					1 🗸 Yes	2 No	1 🗸 Y	es 2 No
J & A. HONEL n of Vital Records ling Physician: The law requirent has been After this certificate has been funeral director, page 2 should	Be	25. Was case referred to med examiner?	dical Hospit	tal:	mt 2 M	ER/Outpa	ationt 3	26.Place of Deat	_	g Home 5	Residence	6 Othe	
of Vital ng Physician: After this certi	٦	1 ✓ Yes 2 No 27. Manner of Death		28a. Date of Inju	iry	28b. Time	e of Injury	28c. Injury at Wo		28d. Describe	e how injury oc		
JS Sion of tending Pleath. After the funera	ertification:	1 Natural 5	Pending	Jan 4, 2007	°°2008	2140 hr	'S	1 Yes 2	√ No		auto collis		
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Divi Divi spital or neral Dir	Cert	4 Homicide	determined	(Specify) Loc									Road, Salisbury, MD
Division To the Hospital or Artent within 24 hours after earth To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyin (Check only one) 2 Medical	Examiner: On	the basis of exa	y knowle mination	dge, death and/or inve	occurred at t stigation, in	the time, date and my opinion, death	occurred a	at the time, dat	te and place, a	nd due to	the cause(s)
To the with To the company of the	Medical	29b. Signature and title of ce	and	I manner stated.				29c. License numb			29d. Date	signed (M	lonth, Day, Year)
		Unellane.	The UK	rell				O.C.M.E.			January	6, 2008	3
K ga		30. Name and address of pe					11 Porn	Street, Baltimo	re MD	21201		C	CME
		Margarita Korell M		tant Medical	Examı ar's Signa		Penns		, C, IVID				

Registrar

			State of Maryland / Departme 1 - State Registary NEND#23a, Pt. 2, perMD, 1/18/08, DPS, McocCertification	nt of Health and Mental Hygiene 1008 02849
	Physici /Medic		1. Decedent's Name (First, Middle, Last) LAWRENCE WILLARD CALLEN, JR.	2. Date of Death Month Day Year JANUARY 12, 2008 3. Time of Death 9:12 A M
>	Examin		HOLY CROSS HOSPITAL SILV	y, Town, or Location of Death VER SPRING 4c. County of Death MONTGOMERY
	Funeral Director		5. Social Security Number 434-36-5257 Usual Residence of Decedent 6. Sex 10 M 2 F 7. Age (In yrs. last birthday) 80 Yrs. Wonths	er 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APRIL 3, 1927 Surface (State or Foreign Country) LOUISIANA
	Maryland t-f show fled at	tor	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☐ Yes 2 💆 No
	th with the 23a or 28a ist be not	al Director	10e. Street and Number 10f. Z 1117 TIFFANY ROAD 20	2ip Code 10g. Citizen of What Country? USA
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	3 ☐ Widowed 4 ☐ Divorced If Yes, Give AND 1 ☐ Yes	redent of Hispanic Origin? (Specify Yes or No- pecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	d within 72 hogiene. sr than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 16a. Decedent's Us (Give kind of w life. DO NOT AUTHOR	vork done during most of working
Maryland	ould be file Mental Hy arked othe atic event,	To Be (17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname) EMILY A. BARROUQUERE
, Mar	and 2 shi raith and 1 27 is m er traum			ss (Street and Number or Rural Route Number, City or Town, State, Zip Code) E DRIVE, SILVER SPRING, MD 20901
Baltimore,	Pages 1:		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Nacemetery, crematory or PARKLAWN MEMORIA)	r other place)
Balt	permit. Departi Import any Inj		21. Signature of Funeral Service Licensee 22. Name a 11800 N	and Address of Facility HINES-RINALDI FUNERAL HOME, INC. EW HAMPSHIRE AVENUE, SILVER SPRING, MD 20904
,8760,	Physician /Medical Examiner the prival-transit the brian-transit t	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or righry that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Fig. 5
P.O. Box 68	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□Yes 2□No 9□Unknown 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 3□Ectopic of death 5□Other (standard)	
	equires that en signed t	by	A A A A A A A A A A A A A A A A A A A	
al Reco	g 85 S	Completed		24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 DNo 1 Yes 2 No
Division or Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner? 1	28c. Injury at Work? 1 Yes 2 No
	e Hospital	Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred the control of the control	od at the time, date and place, and due to the cause(s) and manner as stated. on, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier 25b.	9c. License number 29d. Date signed (Month, Day, Year) 1-14-08
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHISH KISHORE TOLIA, M.D., 1500 FOREST GLEN ROAD,	SILVER SPRING, MD 20910
	Sta Registr	te ar	31. Date filed (Month, Pay, Year) 8 2008 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otate of Mary	nama /	Certifica			R	eg. No 2	800	02850	
l.	Physici	an	1. Decedent's Name (First, Middle, La	ast)					2. Date of Dea Month	th Day	Year	3. Time of Death	
	/Medic			r Marios Ca	vas				January	12,	2008	3:30P M	
	Examin	er	4a. Facility Name (If not institution, gi				Town, or Loca	ition of Death			nty of Death		
			802 Coxswain Way 5. Social Security Number 6.		n yrs. last bi		polis r1Year IfU	Inder 24 Hrs.	8. Date of Birth		Arund	le1 place (State or Foreign	
	Funeral Director		, , , , , , , , , , , , , , , , , , , ,	1 M 2 □ F 82	r yra. idat bi	Yrs. Months		ours Min.	Nov.3,	, Year)	Cou	ntry) le Island	
	/land ow at		10a. State 10b. County	10	c. City, Tov	n or Location						10d. Inside City Limits	
	Mary Fied a	to	Maryland Anne Ar	undel .	Annapo	olis						1 ☐ Yes 2 No	
	or 28s	Funeral Director	10e. Street and Number			10f. Zi	p Code		1	0g. Citizen o	of What Cou	intry?	
	th wil	al D	802 Coxswain Way			21	401			USA	A		
	r dea ems	ne	11. Marital Status	12. Was Decedent Eve Armed Forces?		13. Was Dece	dent of Hispan	ic Origin? (Spe exican, Puerto I	cify Yes or No- Rican, etc.)	14. R	Race - Ameri Black, White,		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:	WWII	1 □ Yes	77	ecify:			cify:Whit		
5	72 h 'natu dicai	ete	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a	a. Decedent's Usu (Give kind of wo life. DO NOT u	al Occupation ork done during	most of working	ng I	16b. Kind of	Business/Ir	ndustry	
121	vithin ne. han '	ם	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		onomist:	ise retired)			Fadam	-1 C		
2	iled v Hygie ther t	ပိ	17. Father's Name (First, Middle, Las		1150	JOHOMITSE	18.1	Mother's Name	(First, Middle,			rernemt	
and	d be 1	Be c	Thomas Arthur Ca	•				orgia	,		,		
Z	should mark	ို	19a. Informant's Name/Relationship		19	b. Mailing Addres				r, City or Tov	vn, State, Zi	p Code)	
$\mathbf{\Sigma}$	nd 2 suith ar		Barbara L. Cavas		I	02 Coxswa	•			-			
<u>6</u>	s 1 ar f Hea item		20a. Method of Disposition		20b. Place o	of Disposition (Na ery, crematory or	me of		ate	20c. Locatio			
E O	Page ent o nt: If ry or		1 X Burial 2 □ Cremation 3 (4 □ Donation 5 □ Other (Spec	_nemoval nom state				m 1/16	/2008 (nounc	v:11a	MD	
Baltimore,	mit. partitr porta porta / inju		21. Signature of Funeral Service Lice	nsee		and Vete	nd Address of	Facility Geor	ge P. I	Calas	Funera	al Home	
ñ	e a la l		When flet			2973 S	olomons	Island	Rd. Ed	lgewat	er, Mo	1.21037	
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the	death. Do	not enter the mo	de of dying, su	ch as cardiac o	r respiratory arr	est,		Approximate Interval Between	
	Physiclan		Immediate Cause (Final disease or condition	. GLIDBI	ASTON	UW AL	LITTEN	SME			- 1	Onset and Death	
1	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence	of):							
	Examiner	L.	Sequentially list conditions, b.										
	ed sit	ine	Sequentially list conditions, if any, leading to intiminediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): Due to (or as a consequence of):										
	xecut and il-trar	xan	that initiated events resulting in death) Last	c Due to (or as a co	onsequence	of):					-		
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687	ficate physis the	edic		d									
Box	n certi nding use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf						23d.	23d. Date of delivery		
	death e atte d for	icia	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Vee 2 No. 4 Pregnant at time of death 5 Other (specify)								Month	Day Year	
Ö.	t the by the	hys	9 ☐ Unknown	9□Unknown									
S, D	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions	contributing to death but n	ot resulting	in the underlying	cause given in	Part I.	23e. Did to			the cause of death?	
ord	equire en si ould b								1 D Y	es 2 No	3	bbably 4 □Unknown	
Records,	ne law ra has be ge 2 sho	Completed							24a. Was a		b. Were aut	opsy findings available ompletion of cause of	
	hysician: The la his certificate has I director, page 2	E O							perfor	med? 2 2 No	death? 1 ∐ Yes	200	
ita	slan: ertific ctor.	Be (25. Was case referred to medical examiner?				1	Place of Death	(Check only or	ne)			
7	Physician: r this certific ral director.	မှ	1 ☐ Yes 2 No			utpatient 3 D		☐ Nursing Hor		ence 6 □0		ify)	
n	ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y			28c. Injury at Work?		28d. Describe h	ow injury occ	curred		
Division or Vital	Attending r death. ector: After by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not	00	A h h = m = 4	M	1 ☐ Yes		206 (1' 70			10-1-11	
Ξ	or At offer d Direct in by	E	4 ☐ Homicide determine		Specify)	arm, sireet, racto	ry, office	4	City or Tow		imber or Hui	ral Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.		29a. Certifier 1 Certifying F	hvsician: To the hest of n	nv knowledr	re, death occurred	d at the time. d	ate and place	and due to the	ause(s) and	manner as	stated.	
	24 hr 24 hr 3 Fun etely	Medical	(Check only 2 Medical Exa	hysician: To the best of n miner: On the basis of ex and manner stated	amination a	nd/or investigatio	n, in my opinio	n, death occurr	ed at the time,	date and plac	ce, and due	to the cause(s)	
	To the within To the Comple	Me	29b. Signature and title of certifier	2000	\cap	29	c. Libense nun	nber	2	29d. Date sig	ned (Month	, Day, Year)	
	->	-	> veter VI	111 85 111			DIK	0364	+	1/1	410	1	
	AXXX	14	30 Name and address of person wh	complete lause of death	h (Itom-28a)	(Type, Print)	1 2 :		1 1		1	1/21	
_	0 1/20		YEDER GRAPLE	Muart	tsil	MAFR	7 30D	mw	17/11	ull) 214	101	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Redistrar's	Signature								

Registrar

JAN 1 6 2008

			1 - For Stata Registrar	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Beautiful Beaut	008 02851
		de	Decedent's Name (First, Middle, La	Treg. Ito.	2 Time of Death
	Physici	an	1 1	Month Day	3. Time of Death
16	/Media		Charles	Monroe Camper, SR. Jan. 18	2008 7:408
1	Examir	er	4a. Facility Name (If not institution, giv		County of Death
			Chesapeake	Woods Center Cambridge Do	orchester
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 rs. 8. Date of Birth	Birthplace (State or Foreign Country)
	Director		212.16-72 75	1 PM 2 F 89 Yrs. Months Days Hours Min. (Month, Day, Year)	918 Maryland
100			Usual Residence of Decedent		Tid Maryiaris
	/lanc		10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
	th with the Marylar 23a or 28a-f show	ō	MD Dorch	· Clara Huntack	1 🗹 Yes 2 🗌 No
\mathbb{Z}	198 - 88a-	Funeral Director	10e. Street and Number		
J	ig 6	늅			en of What Country?
Q	23a	a	116 Gold Rus	h Lane P.O.Box 618 2/643	USA
K	items	Je.	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	4. Race - American Indian,
9	or ite	E	1 Never Married 2 Marned	1 Ves 2 No / 9 4 2	Black, White, etc.
8	urs a	þ	3 Widowed 4 ☐ Divorced	If Yes, Give 1 ☐ Yes 2 ☑ No Specify: S	Specify: Black
5-0036	72 hours alter death with the Maryland naturet', or items 23a or 28a-f show idical Examiner must be notified at	e d	15. Decedent's E	Education 16a. Decedent's Usual Occupation 16b, Kind	d of Business/Industry
215	in 7	Completed	(Specify only highest gra	(Give kind of work done during most of working life. DO NOT use retired)	
212	within ene. then "	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)	1) 0
	Hygie Hygie ther	ပိ	17. Father's Name (First, Middle, Last,		od Cannery
Ĕ	be t d of	Be	A		sumarne)
<u>8</u>	should be nd Mental marked o	ဥ	Charles	E. Camper Georgia Yo	una
Maryland	2 should be tiled within and Mental Hygiene. is marked other then eumatic event, the Mental Men	F 54	19a. Informant's Name/Relationship (Town, Stale, Zip Code) 21643
		3	Glanpice (amper 116Gold Rush Lane P.O. Box 618 /	HUNLOCK MD
<u>ත</u>	s 1 and of Health Item 27 other tr		20a. Method of Disposition	20b. Place of Disposition (Name of Date 20c. Local	ation - City or Town, State
2	00		1 ZBurial 2 Cremation 3	Internoval non state	The last of groups
3altimore,	permit. Pag Department Important: ti eny injury o		4 □ Donation 5 □ Other (Specif	The Mrs 181010 Celviere 4	APSONTOWN, MD
<u>a</u>	Departiment Departiment Department Departmen		21. Signature of Funeral Service Licer	insee / 22. Name and Address of Facility	,
-	907 9 d		Jonelle	C. Denry Henry Funeral Home, P.A. bri	dae, MD. 2/6/3
-			23a. Part1, Enter the disease, or com	nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rone cause on each line.	Approximate Interval Between
	Dhysician		Immediate Cause (Final	one caused in each lane.	Onset and Death
10	Physician /Medical		disease or condition resulting in death)	a. Lemanca	year-
_					
	Examiner			Due to (or as a consequence of):	
ı	Examiner	_	Sequentially list conditions.	. Hy se Leasur	year-
	Examiner	iner	Sequentially list conditions, if any, leading to animediate cause. Enter Underlying	Due to (or as a consequence of): Due to (or as a consequence of):	year-
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0,	Examiner	Examiner	Sequentially list conditions, if any, leading to animediate cause. Enter Underlying	. Hy se Leasur	year-
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08-00630 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Solomon Dixon State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day January 22, 2008 Medical Examiner SOLOMON RUSSELL DIXON 2026 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Shady Grove Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or **Funeral** 6. Sex 7. Age (In yrs. last birthday) oreign Months Days Hours Director 214-79-1626 X M 2 June 12,200 Country) MD Usual Residence of Deceden 10a. State 10d. Inside City Limits 10c. City, Town or Location items 23a or 28a-f show ust be notified at once. 1 Yes 2 X No MD Montgomery Gaithersburg Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1184 Southern Night Lane 20879 U.S.A. Funeral Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: injury or other traumatic event, the Medical Examiner must be. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. 1 X X Never Married 2 Married 2X No If Yes, Give Year 2X No specify: Black Widowed Divorced Specify: Yes ≥ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) more, MD 21215-0036 Pages 1 and 2 should be filed within 7. Ient of Health and Mental Hygiene. N/A N/A 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Wayne Dixon, Jr Maketa Patterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0,879 19a. Informant's Name/Relationship (Type, Print) ^(Mother) 1184 Southern Night Ln, Gaithersburg, MD Maketa Dixon 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c Location - City or Town, State Baltimore, 1X Burial 2 Cremation 3 crematory or other place) Removal from State 1/31/08 Parklawn Mem Park Rockville, MD 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SNOWDEN FUNERAL HOME 246 N. Washington St, Rockville, MD 20850 George R. Snowden, per DVR 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Sudden Infant Death Syndrome (SIDS) Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED has been signed by the attending physician 2 should be detached for use as the burial. AMENDED perFD, g877 3/11/08 TT **23a,27 per me g877 3-21-08 vt** Records, P.O. Box 68760, IF FEMALE 23c. If ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has death? performed? ✓ Yes 2 No 1 🗸 Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Other; Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Pending Yes 2 No

Division (

Hospital or Attending Physician; 24 hours after death. neral Director; After t To the Funeral

2

3

Medical

State

Accident

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifier

Ana Rubio MD 31. Date filed (Mo

Investigation

Could not be determined

30. Name and address of person who completed cause of death (Item 23a)

2008

Assistant Medical Examiner

Registrar DHMH 17 Rev 1/2001 **OCME 2006**

egistrar's Signatur

28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E

28f. Location (Street and Number or Rural Route Number, City

January 23, 2008

29d. Date signed (Month, Day, Year)

			1 - For Amend Item Registrar	State of M 24a per d	larylan r., g8	d / Depa 76,02 /	artment 16/08d	of He	ealth a Death	and Mei	ntal Hy	giene Reg. No	20	08	028	53
1			1. Decedent's Name (First, Middle, I								Date of De	eath		V	3. Time of E	Death
	Physici /Medi		Nancy Virginia D	eStefano						J:	Month anuar	y O	9 20	908 008	1:00	Рм
	Examir	ner	4a. Facility Name (If not institution, g		r)		4b. City, To			of Death			County			
		4	503 Captain John				Annap			0411=			nne .	Aruno		
	Funeral Director		220-48-3298	. Sex 7. A	ige (In yrs. 75	last birthday) Yrs.	If Under 1 Months	Days	If Under : Hours	Min. 0	Date of Bir (Month, Da 5/28/	th ay, Year) 1932	1	Cour	lace (State or itry) ington,	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation	-						1	0d. Inside City	/ Limits
	Mary a-f sh	tor	Maryland Anne A	rundel	Anna	apolis									1 Yes	2 X No
	th the or 28; e not	Jirec	10e. Street and Number				10f. Zip C					10g. Cit	izen of W	hat Cour	ntry?	
	ath w	ral	503 Captain John				2140							State		
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1	s?] No		Was Decede If Yes, specif 1 □ Yes 2		spanic Origin, Mexican Specify:	gin? (Specifi n, Puerto Ric	y Yes or No an, etc.))-		k, White,		
9	72 hou natura ical E	ted	15. Decedent's (Specify only highest t	Education		16a. Dece	dent's Usual kind of work	Occupa	tion	t of working		16b. K	ind of Bu	siness/Inc	dustry	
21215-0036	ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12)	College (1-4or	r 5+)	lite. i	DO NOT use	retired)	aning mosi	t or working		- ,,				
2	Hygie Hygie ther th	S	17. Father's Name (First, Middle, La	_		Homem	aker		18 Mathe	er's Name <i>(F</i>	irst Middle	Ho		- A)		
Maryland	d be f antal h ced of	Be C	William Earl Har	*					Doro	,	-	Jones		6)		
ary	shoul nd Me marl	၉	19a. Informant's Name/Relationship			19b. Mailir	ng Address (5	Street a						State, Zip	Code)	
	and 2 alth a 27 is		Gina M. DeStefan	o/Daughter		820 N	orthfi	eld	Lane	, Cro	wnsvi	11e,	Mar	yland	1 21032	
ore.	of He of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□ Pomoval from State		Place of Dispo	sition (Name natory or oth	of er place)	Date	;	20c. Lo	ocation -	City or To	wn, State	
Ē	Pag ment ant: I		4 □ Donation 5 □ Other (Spe	cify)		ar Hil	1 Ceme	ter	v 0	1/14/0	08	Suit	land	, Mai	ryland	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any Injury or other traumatic event, the Mesone.		21. Signature of uneral price ki	42		2	973 So	1om	ons I	sland	Rd.,	Edge			al Home 21037	
Į,			23a. Par 1. Enter the disease, or co shick, or heart failure. List or	emplications that cause ly one cause on each	ed the death line.	h. Do not ent	er the mode	of dying	, such as	cardiac or re	espiratory a	irrest,			Approximate Interval Betw Onset and D	reen
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a_ M6	relet	51646	1915								241	2
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Ő,	cate be executed oblysician and the burial-transit	Ë	resulting in death) Last	Due to (or a	s a consequ	uence of):										
8760,	cate b	dical		d												
P.O. Box 6	death certifi e attending I d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	23c. If yes, outcom 1 □Live birth 4 □Pregnant 9 □ Unknown	2 Feta	Ideath 3	Ectopic prec Other <i>(sp</i> ec						23d. Date Mor	e of delive		ear
	res that signed by be deta		Part II. Other significant conditions	s contributing to death	but not resu	ulting in the u	nderlying cau	se give	n in Part I.		23e. Did	tobacco i	use contr	ibute to the	ne cause of de	eath?
rds	w requires been sign should be	ed by									1 🗆	Yes 2	□No	3 ☐ Prob	ably 4 □U	nknown
Records,	e las has e 2	Completed									24a. Was auto perfo 1□ Yes		p	prior to co death?	psy findings a mpletion of ca	vailable use of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?					T		of Death (C	heck only	one)				
or/	dir dir	은	1 Yes 2 100	Hospital: 1 Inpat		ER/Outpatier			4 □ Nu	rsing Home					y)	
UC.	allng P. After funer	ion	27. Manner Peath 1 University of the second	28a. Date of In (Month, D	Jury Pay Year)	28b. Time of Injury	M 280	lnjury Work′	at ? ′es 2∐I		I. Describe	how inju	ry occurr	ed		
Division	Attending r death. ector: After y the fune	licat	2 Accident investigat 3 Suicide 6 Could not	be loop Blace of it	njury - At ho	ome, farm, str			es 2 🔲 i		Location (Street ar	nd Numb	er or Rura	al Route Numb	oer.
Ö	al or A after I Dire	Certification:	4 ☐ Homicide determine	building,	etc. (Specify	y)					City or To	wп, State))			,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis and manner s	st of my kno of examina stated.	wledge, deatl tion and/or in	h occurred at vestigation, in	the tim	e, date an inion, dea	nd place, and ath occurred	due to the at the time	cause(s , date an) and ma d place, a	inner as s and due to	tated. the cause(s)	
	To the To the Comp	M	29b. Signature and title of certifier)()			29c. l	License	number			29d. Da	te signed	(Month,	Day, Year)	
	20,	00	L-loux	Heere il	2		D	000	189	229	170	0	16-	09	-200	5
_	1/10	3	30. Name and address of person when 2009 TivewATE	2 Colonu	death (Item	wledge, death tion and/or in n 23a) (Type, ture	Print)	115	M	10 2	1401	/ J	on E	3. L	owe	
	Sta Registi		31. Date filed (Month, Day, Year)	2008 32. R	trar's Signá	ture /	foods	,								

			State of Maryla State of Maryla Registrar		artment of Heal rtificate of Dea			giene 0	8 02854
п	COLUMN TO SERVICE STATE OF THE PERSON STATE OF		1. Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death
	Physicia		Robert Eldo	on Di	ietsch		Month Januar		08 12:40 A ^M
in the	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca	ation of Death		4c. County of	
	LXaiiiii	-	Frederick Memorial Hospital		Frederic	k		Fred	erick
	Funeral			s. last birthday)	If Under 1 Year If U	Inder 24 Hrs.	8. Date of Birth	1 9	Birthplace (State or Foreign
	Director		287-12-3947 ^{1⊠ M 2□ F} 85	Yrs.	Months Days Ho	ours Min.	(Month, Day July 31	, rear)	Country) Ohio
Ď.			Usual Residence of Decedent				July 31	, 1, 1, 2, 2	OHLO
	yland now at		10a. State 10b. County 10c. C	city, Town or Lo	cation				10d. Inside City Limits
	Mar -f st	ţ	Maryland Frederick M	t. Airv					1 ☐ Yes 2 No
	the	rec	10e. Street and Number	c. mil	10f. Zip Code			10g. Citizen of Wh	at Country?
	death with the Maryland ms 23a or 28a-1 show r must be notified at	Funeral Directo	5811 Catoctin Overlook Drive		2177	1		United	Statos
	ms 2	era	11 Marital Status 12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hispan If Yes, specify Cuban, Me		cify Yes or No-		American Indian,
	r iter	2	Armed Forces? 1 □ Never Married 2 Married 1 1 1 1 Nover 2 Nover 1 1 1 1 Nover 1 Nove 1 Nover 1 Nove 1 No				Rican, etc.)	Black,	White, etc.
- - - -	ars a	ò	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: WWI		1 ☐ Yes 2 ☒ No Sp	ecify:		Specify:	White
Ş	72 hours after natural", or ite dical Examine	Completed	15. Decedent's Education	16a. Dece	dent's Usual Occupation			16b. Kind of Busi	
<u>.</u>	nin 7. n "n Medi	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done during DO NOT use retired)	g most ot workin	ng		
7	within 7 liene.	E	12	Sys	tems Analys	t		IMB	
0	Hyg othe ent,	BeC	17. Father's Name (First, Middle, Last)		18. 1	Mother's Name	(First, Middle,	Maiden Surname))
yland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Memtal Hyglene. If Health and Memtal Hyglene frem 27 is marked other than "natural" or items 28a or 28a-f show other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at	To B	Albert Dietsch		F	rances	Rau		
<u></u>	should ind Men marke		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and N			er, City or Town, S	tate, Zip Code)
Ĕ	and 2 sealth ar n 27 is ier trau		David Dietsch/ Son	5811	Catoctin O	warlook	Drive	Mr Airs	MD 21771
တ်	Hea Hea tem			Place of Dispo	osition (Name of		ate		ity or Town, State
<u></u>	ages int of t: # H		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State		matory or other place)				
Baitimor	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once.		4 □ Donation 5 □ Other (Specify) S 21. Signature of Funeral Service Licensee		Crematory 2. Name and Address of		3/08	Frederic	k, Maryland
g	Depa Impo any i		21. Signature of the last Sevice Licensee	នុំ	tauffer Fund	eral Hor	ne P. A	٠.,	Maryland21702
			South Birthand						Maryland21/02 Approximate
			23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only on ause on each line.	ath. Do not en	ter the mode or dying, su	ich as cardiac o	r respiratory ar	rest,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	5					
	/Medical Examiner		resulting in death) Due to (or as a conse						
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	D #	iner	that initiated events Sequentially incommediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	nce of):		0			
	ecute and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last						
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X Q Q	death certif e attending id for use as	an/	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy			23d. Date Mont	of delivery th Day Year
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ř	The I	E					perfo	rmed? de	eath? □Yes 2□No
Vital Records,	slcian; The law certificate has t irector, page 2 s	Be C	25. Was case referred to medical		26.	. Place of Death			
	> 0 0	0	examiner? 1 Yes 2 No Hospital: 1 npatient 2	☐ ER/Outpatie	nt 3 DOA Other: 4	4 □ Nursing Hor	me 5□Resid	dence 6 □Othe	(Specify)
DIVISION OF	ding Phys h. After this funeral dir	Ë	27. Manner of Death 28a. Date of Injury	28b. Time o				how injury occurre	
Ö	mdin ith. r: Aft	ţ	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	injury		2 🗆 No			
SIS	Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At building, etc. (Spe	home, farm, st	reet, factory, office	2	28f. Location (S	Street and Number	r or Rural Route Number,
ā	al or s afte i Dir	ert	4 ☐ Homicide determined building, etc. (Spe	cny)			City or To	wii, State)	
	spita nours nera y fille		29a. Certifier 1 Certifying Physician: To the best of my k	nowledge, dea	th occurred at the time, d	date and place,	and due to the	cause(s) and man	ner as stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	ınation and/or ii	nvestigation, in my opinic	on, death occurr	ed at the time,	date and place, a	nd due to the cause(s)
	To the within To the comp	Me	29b. Signatule and title of certifier		29c. License nur	mber		29d. Date signed	(Month, Day, Year)
) Ple My		D006	0417		1-17	-08
8	1200	1	30. Name and address of person who completed cause of death (II	tem 23a) (Type	-				
1	AL.		4 .	mas -	1	Dr. F	rede	MCK A	15 2170)
	Sta	ite	31. Date filed (Month, Day, Year) 32. Pegistrar's Sig	nature					
	Regist	ar	JAN 2 2 2008 Angue	K A	1000				

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla		artment of H		d Mental H	ygiene Reg. No.	2008	02855
	Physicia	an	1. Decedent's Name (First, Middle,	Last)			· · · · · ·	2. Date of I	Death		3. Time of Death
-	/Medic	al	Robert Newton	Duncan				Januar	-		5:30 PM
1	Examin	er	4a. Facility Name (If not institution, 103 E. Main Str			4b. City, Town, or Thurmont	Location of De	eath		County of Death ederick	
	Funeral			6. Sex 7. Age (In vrs	s. last birthday)	If Under 1 Year	If Under 24 H		Birth	9. Birth	place (State or Foreign
	Director		030-20-3689	1ĂM 2□F 78	Yrs.	Months Days	Hours M	May 27	, 192	9 Mass	achusetts
	and		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ocation					10d. Inside City Limits
	Mary I-f sho	tor	MD Freder	ick Thu	ırmont						1 Yes 2 □ No
	th the or 28s e noti	Director	10e. Street and Number	****		10f. Zip Code			10g. Citiz	en of What Cou	intry?
	ath wi		103 E. Main Str			21788			USA		
	ter de Items	Funeral	11. Marital Status 1 ☐ Never Married 2 M Marrie	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? an, Mexican, Pu	' (Specify Yes or I uerto Rican, etc.)	No- 1	 Race - Ameri Black, White 	
920	urs af al'; or Exam	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1951	L - 53	1 □ Yes 2 🗖 No	Specify:			Specify: Whi	te
2-0	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. dother than "natural"; or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent' (Specify only highest	s Education t grade completed)	(Give	dent's Usual Occup	during most of v	workina	16b. Kin	nd of Business/Ir	ndustry
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<u>a</u>		To Be	James Duncan				Alice	Newton			
Maryland 21215-0036	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationsh	ip (Type. Print)		ng Address (Street					ip Code)
<u>ک</u> ت	ss 1 and of Health item 27 other tr		Doris A. Duncan 20a. Method of Disposition			E. Main Apposition (Name of	treët T	hurmont,		1788 cation - City or T	in State
0			1 ☐ Burial 2 X Cremation	3 □Removal from State	cemetery, cre.	matory or other place se Cremate				sville,	· ·
altimore,	permit. Page Department of Important: If any Injury or once.		4 ☐ Donation 5 ☐ Other (Sc 21. Signature of Funeral Service I			2. Name and Address	-				
ñ	Dep Imp		Boney L	Heltte 1							e, MD 21029
			23a. Part T. Enter the disease, or c shock, or heart failure. List of	complications that caused the de-	ath. Do not en	ter the mode of dyin	ng, such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a Carci	uoma	of Lung	- m	etastat	rè		3-4 mos.
7	Examiner			Due to (or as a conse	equence of):	0	7 ,				
-4		ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated expenses.)	b. Due to (or as a conse	equence of):						
	ecuted and transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	с							
8760,	be executed sician and burial-transit	al E		Due to (or as a conse	equence oi):						
687	ate hys	edical		d							
ŏ	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf preg 1□Live birth 2□Fe		⊒Ectopic pregnancy	N	A	2	3d. Date of deliv	*
O. B	0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No N A 9 ☐ Unknown	4□Pregnant at time of		Other (specify)	' /		-	Month	Day Year
о <u>.</u>	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditio	ns contributing to death but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Di	d tobacco us	se contribute to	the cause of death?
Records,	quires than signed I	d by		_				1[Yes 2]No 3∏Pro	obably 4 Conknown
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Vita	slcian: Tr certificate rector, paç	Be (25. Was case referred to medical examiner?	Harrisol		100		Death (Check onl	y one)		
0	Physic ruthis or ral dire	.T	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatie		4 ∐ Nursin	g Home 5 Re		Other (Spec	ify)
Division or	th. : After e funer	tion	1 Natural 5 Pending 2 Accident investig	(Month, Day Year)		Wor	k? Yes 2∐No	Zod. Descrit	e now injury	y occurred	
N S	I or Attencafter death	Certification:	3 Suicide 6 Could n 4 Homicide determi		home, farm, st	reet, factory, office			(Street and Town, State)		ral Route Number,
ō	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certificately filled in by the funeral director, tely filled in by the funeral director,	Cert									
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical I	g Physician: To the best of my k Examiner: On the basis of exami and manner stated.	nowledge, deal ination and/or in	th occurred at the tire evestigation, in my c	me, date and pl opinion, death o	lace, and due to to occurred at the time	ne cause(s) ne, date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	~2 D 1		29c. Licens	e number		29d. Date	e signed (Month	, Day, Year)
,	2 + /		Shad,	200pul	H()	D27	2819	•	1	117/0	8
•	É. G.		30. Name and address of person	who completed cause of death (Its	em 23a) (Type,	B : ::				705 7	17.00
	Sta	te	31. Date filed (Month, Day, Year)	anno 32. registrar's Sig	nature	CONTRACTOR	12 11	TURMO	Ni, I	110, 4	1/00
	Registr		JAN 1 8	5 ZUUO REPORTED	10. 16	THE STATE OF THE PARTY OF THE P					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Day Vasi **Physician** CLAIRE EISNER JANUARY 15, 2008 1:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL BETHESA MONTGOMERY If Under 1 Year Months Days If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 🕱 F Director 94 04/10/1913 053-03-3110 POLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County or 28a-f show Examiner must be notified Director MARYLAND MONTGOMERY **BETHESDA** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6530 DEMOCRACY BLVD 20817 USA 'natural", or items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify. Specify: WHITE 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 CASHIER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL WAPNER DORA SEIDEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS SLAVIN/DAUGHTER 4401 HORNBEAM DRIVE, ROCKVILLE, MARYLAND 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH ISRAEL CEMETERY 01/17/2008 WOODBRIDGE, NEW JERSEY 9 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GASTROINTESTINAL BLEED /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine for use as the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1x Inpatient 2 ER/Outpatient 3 DOA ္ပ 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director; After Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide CC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature

State Registrar

DHMH 17 Rev 1/2001

ed cause of death (Item 23a) (Type, Print)

Bgistrar's Signature

ress of person who comple DR. NATASHA PRTINA HAAG,

2008

Year

18

31. Date filed (Month, Day,

D62949

8600 OLD GEORGETOWN ROAD, BETHESDA, MARYLAND

JANUARY 15, 2008

20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Fred Grabowsky P^{M} 15, 2008 7:10 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral 15** M 2 □ F 81 152-16-9705 1926 New Jersey Aug. 8, Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Severna Park Maryland Anne Arundel 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 475 Maple Road 21146 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? WDY'es 2 □ No If Yes, Give Year or Dates: 1949–69 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. White Maryland 21215-0036 1 ☐ Yes XXNo Specify ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Lawyer Law 5+ nd 2 should be filed w lith and Mental Hygie 27 is marked other ti r traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic ev Devorta Fajnkuchen Kosrel Grabowsky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 475 Maple Road Severna Park, Maryland Laila Grabowsky/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2☐Cremation 3 ☐Removal from State Baltimore Crematory 1/17/2008 Baltimore, Maryland 4 ☐ Donation _ 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 work **Physician** neumonia /Medical be to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 Acute renu 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Cardion SIN Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month. Day Year) s after death.

I Director: After this d in by the funeral di 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours a To the Funeral I 1 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

completely

State Registrar

(Check only

31. Date filed (Month, Day, Year) JAN 1 32. Register's Signature 2008

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and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peterson

29c. License number

D21804

29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760. attending pt signed by the a should be page 2

Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Scheller Leon Garlock January 3:53 P ^M /Medical 20 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) DEC. 4, 1922 **Funeral** Birthplace (State or Foreign Country) 1 XM 2 □ F Months Days Hours 214-14-9872 85 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4916 Old Swimming Pool 21703 Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Major / officer U.S. Army/Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Scheller Garlock 2 Roberta (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine S. Garlock / Wife 4916 Old Swimming Pool Rd./ Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Stauffer Crematory JAN. 22,2008 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home eanne 1 1621 Opossumtown Pike, / Frederick, MD 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pnemmonia /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and sthe burial-trans actere mia Due to (or as a consequence of): tan Physician/Medical ung IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2⊅No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autops, performed? 2XINo 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: s after death. 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number D0035106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myung Hee Nam / 400 West 7th St./ Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature Registrar 2008

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last) **Physician** HANNAH /Medical Examiner **Funeral** Director ral", or items 23a or 28a-f st Examiner must be notified Director MD Funeral Completed by "natural" permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany Injury or other traumatic event, the Medical Baltimore, Maryland 21215 Be P **Physician** /Medical Examiner Examiner ig physician and as the burial-transit Box 68760 nse for

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Facility Name (If not institution 100m If Under 1 Year if Under 24 Hrs. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ N 2**X** F Hours 12/23/1952 Mary land 55 215-62-1172 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31854 Quail Ridge Drive 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Management Mental Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Francis Dryden Elizabeth Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald L. Goodwin (husband) 31854 Quail Ridge Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rehoboth Presbyterian Cem. 1/22/2008 Rehobeth, MD 21. Signature of Fun rai Service Licensee Holloway Funeral Home, Professional Association Much 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 103 Linden Ave., Pocomoke City, MD 21851 Approximate Interval Between Onset and Death Immediate Cause (Final CARCINOMA OF disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Was a... autopsy performed? page certificate funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ 1 ☐ Yes 1 patient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☐ Natural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation or Attending 1 ☐ Yes 2 ☐ No death. 24 hours after death e Funeral Director: the 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00058410 -18-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POBOX 1733 SHIRBUMS 8A5 HOSPICE COASTAL GHUMAN WARL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

ORIGINAL

P.0. Records,

or Vital

Division

State Registrar

Laron Locke MD.

29b Signature and title of certifie

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 13, 2008

ORIGINAL

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			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	illicate of t	Dealli	2. Date of Dea	th	2008	3. Time of Deat	D Z
	Physicia		Harold Hous	ton Hawf	ield			January	14,	2008	10:30A	М
kte.	/Medic Examin	Sept.	4a. Facility Name (If not institution, give street and r			4b. City, Town, or	r Location of Death			ounty of Death	10.3011	
			2827 Fennel Road			Edgewate				ne Arund		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ns <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	(Year)	Cour	lace (State or For	
	Director		246-05-1102 Table 2 Page 1	00	113.			May 6,	1921	Nort.	h Caroli	na
	yland yland at		10a. State 10b. County	10c. City,	Town or Lo	cation				1	0d. Inside City Lir	nits
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	or 28	Jire	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cour	ntry?	
	ath wi	ral	2827 Fennel Road			21037				SA		
(O	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Armed 1 □ Never Married 2 🕅 Married 1 🕅 Ye	ecedent Ever in U.S Forces? s_2	T	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2Å No	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Black, White,	etc.	
21215-0036	ours a	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Year or	Dates:		1 Li Yes 2ŁLLINO	Specify:			pecify: Whi		
15-0	"natu	Completed	15. Decedent's Education (Specify only highest grade complete	d)	(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most of work	ing	16b. Kind	of Business/Inc	dustry	
121	withir ene. than he Me	dmo	Elementary/Secondary (0-12) College 5+	(1-4or 5+)	Physi		1)		Heal	th Care	!	
	filed Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden St	urname)		
'an	uld be denta rked ric ev	To B	Samuel Glen Hawfield				Kate Cl	ark				
Maryland	shol and N is ma		19a. Informant's Name/Relationship (Type. Print)				and Number or Run				Code)	
	and health		Isolde M. Hawfield/Wife	Jan. Bi			d. Edgewa					
Baltimore,	it of H if ite or otl		20a. Method of Disposition 1 ☐ Burial 2 XX Cremation 3 ☐ Removal fro	m State	_	osition (Name of matory or other place	ce) 1/16	/2008		ation - City or To		
ĦΪ	artmer artmer ortant injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Kal		ematory Name and Addre	ess of Facility Geo		_	ater, M		
Ba	permi Depar Impor any ir		Jan A. Kolm	\			ons Islan	_				
r	1 43		23a. Pan1. Enter the disease, or complications the shock, or heart failure. List only one gause of	t caused the death	. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	, , , ,	Approximate Interval Between	1
	Physician		Immediate Cause (Final disease or condition	ehuds	atu	m				10	Onset and Death	
	/Medical		resulting in death)	to (or as a onsequ	ence of):	1						
8	Examiner	_	Se uentially list conditions b.	Uzher lo (or az a consequ	me	in De	mente	ev			~10 yr	<u>~</u>
	ted nsit	nine	Se wentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1 m & m o	erice oi).)					~ 2 mon	th
,	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last C. Due	to (or as a consequ	ence of):						01 11-	
68760,	te be ysicia ne bur	dical	d									
			IF FEMALE:									
Box	death certific e attending p d for use as	ian/I	23b. Was decedent pregnant	outcome pf pregnar e birth 2 🗆 Fetal	death 3[⊒Ectopic pregnanc	у		23	Bd. Date of deliver	ery Day Year	
	he der the a	Physician/M	1 Yes 2 No 4 Pre 9 Unknown	egnant at time of de known	eath 5L	Other (specify) _						
, P.O	that t led by detac	/ Ph	Part II. Other significant conditions contributing to	death but not resu	Iting in the u	inderlying cause giv	ven in Part I.	23e. Did to	obacco use	e contribute to t	he cause of death	1?
rds	w requires that the de been signed by the s should be detached	d by						101	/es 2□	No 3 ☐ Prol	pably 4 Unkn	own
000	aw rec s bee 2 shou	Completed						24a. Was		24b. Were auto	ppsy findings avail	able
Re	sician: The law certificate has b irector, page 2 s	шо							rmed? 2 X No	death?	mpletion of cause 2□ No	of
ita	slan: ertifice ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Deat		-			
\ \r	Physician: this certific ral director,	2	1 ☐ Yes 2 No Hospital: 1		ER/Outpatie	IK OLI DON		me 5 Resid			fy)	
Division or Vital Records,	ing inel	ion:	1 X Natural 5 ☐ Pending (M.	te of Injury Ionth, Day Year)	28b. Time o Injury	Wo	ryat rk? Yes 2 ∐No	28d. Describe i	now injury	occurred		
isio	Attending r death. ector After by the funer	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pla	ace of injury - At ho	me, farm, st		1163 2 1140	28f. Location (5	Street and	Number or Run	al Route Number.	
á	s after	Serti	4 ☐ Homicide determined bu	ilding, etc. (Specify	()			City or Tov	vn, State)			
	To the Hospital or Attendi within 24 hours after death. * To the Funeral Director A completely filled in by the fi	Medical Certification:	29a. Certifier 1 ★ Certifying Physician: To (Check only one) 1 ★ Medical Examiner: On the and m	the best of my know e basis of examinat anner stated.	wledge, deat tion and/or in	th occurred at the tinvestigation, in my	me, date and place, opinion, death occu	, and due to the rred at the time,	cause(s) a date and p	and manner as s place, and due t	stated. to the cause(s)	
_	To th withir To th comp	Me	29b. Signature and title of certifier	L :		29c. Licens	se number		29d. Date	signed (Month,	Day, Year)	
7	2/40	1	(Check only 2 Medical Examiner: On the and mone) 29b. Signature and title of certifier Marcy D Fricero 30. Name and address of person who completed control of the completed of the complete of the complet	-King,	MO.	Do	0040904	<i>f</i>	Jan	wary 15	2008	
	100		30. Name and address of person who completed c	ause of death (Item	23a) (Type,	Print)	A 1	/	\	1.	A1D a	
	17°		31. Date filed (Month Day Year)	1 g, m.O.	120	09H 1113	arda La	ive, F	NNa	polis,	W) 214	03
	Sta Regist	ite rar	JAN 1 6 2008	Aleen	K.	Seed .						
DI	MH 17 Boy 1/2	001			-							

Registrar DHMH 17 Rev 1/2001

Henry Percy Hutton	, Jr. State o	f Maryland / Dep C	partment of ertificate of		Mental Hy	giene Reg.	200	8 0286
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Henry P. Hutton					Date of Death Month D January 11,		3. Time of Death 2251 hrs
	4a. Facility Name (if not institution, give s 413 North Port Street	street and number)	4	b. City, Town, or L Baltimore	ocation of Death		4c. County of Dear	h
Funeral Director	5. Social Security Number 6. Sex 214-40-2575 1X N	7. Age (In yr	s. last birthday) 65 Yrs.	If Under 1 Year Months Days		8. Date of Birth() May 15	MM/DD/YYYY) 9. B Fore	
d اعتداد how any	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. C	ity, Town or Locati					10d. Inside City Limits 1 Yes 2 X No
n with the Maryland ms 23a or 28a-f show be notified at once. eral Director	10e. Street and Number 413 North Port			10f. Zip Code 2122	24	10g.	. Citizen of What Co	11
or ite	1 Never Married 2 X Married	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 No Yes, Give Year 1975 – or Dates:	If Y		panic Origin? (Spe Mexican, Puerto R specify:		14. Race - Ame White, etc.	rican Indian, Black,
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after nt: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Completed by I	15. Decedent's Education (Specify only Elementary/Secondary (0-12) 12th	College (1-4 or 5+) 1½ YYS) 16a. Deceden during me		on (Give kind of wo DO NOT use retire	d)	6b. Kind of Business Gunther Crucking	•
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical plury or other traumatic events.	17. Father's Name (First, Middle, Last) Henry P. Hutton			1	8.Mother's Name (I	First, Middle, Mai Davis	iden Surname)	
, MD 21 and 2 should ealth and Me cen 27 is ma traumatic ev	19a. Informant's Name/Relationship (Type Diane Hutton (With 20a. Method of Disposition	Ee)	1	North P	ort St.	Baltir	er, City or Town, State More, Md 20c. Location - City of	. 21224
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	1 Burial 2 X Cremation 3 4 Donation 5 Other Specify: 21. Signature of Funeral Service License	Removal from State M	etro Cr	erplace) ematory	1-1	8-08	Baltimor	e, Md.
Physician	Jacony J, Aseae Mc 3a. Part I. Enter the discusse, or complic failure. List only one cause on each		82	1 West	St. Ann	apolis	, Md. 21	
/Medical caminer	Immediate Cause (Final disease or condition resulting in death)	ypertensive Atheros ue to (or as a consequenc		ovascular Dis	ease			Death
led Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	ue to (or as a consequenc						
D, be execui sician and urrial - tra	d. UNPENDED	AMENDED				· · · · · · · · · · · · · · · · · · ·		
D. Box 6876C the death certificate by the attending phys sched for use as the b Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of point of Live birth Pregnant at time of guntary Unknown	2 Fe	tal death 3 [her (Specify)	Ectopic pregnan	су	23d. Date of delive Month	ery Day Year
ords, P.O. w requires that the sabeen signed by t should be detache pleted by PP	Part II. Other significant conditions of Diabetes mellitus, prostate			nderlying cause g	iven in Part I.			o the cause of death? obably 4 Unknown
tal Records, cian: The law require certificate has been si ector, page 2 should be Be Completed						24a. Was an autopsy perform	prior to ned? death?	
n of Vital ling Physician: After this certifuneral director	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	spital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year)	ER/Outpatient 28b. Time of I	3 DOA Onjury 28c. Injur		Home 5 R	esidence 6 Othow injury occurred	ier: Scene
Division o Bivision of Attending 24 hours after death Funeral Director: After teely filled in by the funeral of the funeral o	3 Suicide 6 Could not be determined	28e. Place of Injury - A (Specify)				or Town, Sta	ite)	Rural Route Number, City
To the How within 24 h To the Fin completely Medical ((Check only one) 2 Medical Examiner:	n: To the best of my know On the basis of examination and manner stated.			death occurred at	the time, date an		the cause(s)
	Milina Beass 30. Name and address of person who co	ell MV	tem 23a)	O.C.N			January 12, 20	
State	31. Date filed (Month, Day Year)	istant Medical Exar Registrar's Sign		enn Street, B	altimore, MD 2	21201		
Registrar DHMH 17 Rev 1/2001	OCME OCME	January .	ORIGINA	L		-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiane O. O. O.

				1 - For State Registrar				rtificate of	f Death		Reg. No	2000	02004
	П	Physici	an	Decedent's Name (First, Middle, L.	ast)					2. Date of De Month	ath Da	ay Year	3. Time of Death
		/Medi		Teresa Jane Hoke						Januar	y 1	7, 2008	6:30 PM
		Examir	ner	4a. Facility Name (If not institution, gi	ve street and number,)		4b. City, Town,	or Location of Death	1	40	c. County of Death	1
				Homewood At Crum				Frede				Frederic	
	п	Funeral			Sex 7. A	ge (In yrs.	last birthday) Yrs.	If Under 1 Yea Months Days		8. Date of Bir (Month, Da			place (State or Foreign untry)
		Director		215-14-1726 Usual Residence of Decedent	111	94	ł			Novembe	r 10	6, 1913	Maryland
		laryland show		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
		vith the Maryla or 28e-f shor	ctor	Maryland Frederi	ck	Fred	lerick						1 ☐ Yes 2 🛣 No
		ih th or 28	Sire.	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cou	untry?
		23e	100	7407 Willow Road				21702			Uni	ted State	es
2		r dea	i ei	11. Marital Status	12. Was Decedent Armed Forces	?	.S. 13.	Was Decedent of	Hispanic Origin? (Spinan, Mexican, Puert	pecify Yes or No o Rican, etc.))-	14. Race - Amer Black, White	
0.00	36	filed within 72 hours after death with the Maryland Hygiene. uther than "naturs!", or iteme 23e or 28e-f show uther, I'm Mexilical Exactinger relating at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	İ	1 □ Yes 2 N				Specify:Whi	
	5-0036	72 hours natural,	Completed	15. Decedent's I	ducation		16a. Dece	dent's Usual Occi	upation	trin a	16b. F	Kind of Business/I	ndustry
\sim	2121	thin 7	lg.	(Specify only highest g Elementary/Secondary (0·12)	College (1-4or	5+)	life.	DO NOT use retir	e during most of wor. red)	king			
100	21	e filed withir al Hygiene. I other than vent, the M	ő	12			Homen	naker			O	wn Home	
	pu	be file d oth	Be	17. Father's Name (First, Middle, Las	t)				18. Mother's Nan	ne (First, Middle	, Maidei	n Sumame)	
	Maryland	Men	10	John Hilleary J	amison				Cora Ger	rtrude B	est		
> 0	a	2 sho and is m		19a. Informant's Name/Relationship	(Type, Print)			-	et and Number or Ru		_		
_		Heelth tem 27		Margaret L. Krow	(daughter)				ring Oak (Ct. Jens	en]	Beach, F	L 34957
801111	Baltimore,	of He		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3	Removal from State	1 ~	Place of Dispo semetery, crea	osition (Name of matory or other pl	lace)	Date	20c. L	ocation - City or 1	Town, State
	Ē	Pag ment ant: ury o	١.	4 Donation 5 Other (Spec					ery Jan.				
	at	permit. Pages 1 Depertment of H Important: If its eny injury or ot		21. Signature of Funeral Service Lice	nsee		22	2. Name and Add	ress of Facility Sta	auffer F	'une	ral Home	s PA
	<u> </u>	89229		/ Tacqueline	4. 100	llter			sumtown Pi			ck, MD 2	1702
\supset	п			33a. Part1. Enter the disease, or con shock, or heart failure. List on	netications that cause	d the deat	not ent	ter the mode of dy	ying, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition	//	In a							Onset and Death
	1	/Medical		resulting in death)	Due to (or as	s a conseq	uence of):	na					o cray
		Examiner											
			Je	Sequentially list conditions, if any, leading to firm offate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	s a conseq	uanno of):						
		rificate be executed og physicien and as the burial-transit	Examiner	Cause (Disease or injury that initiated events	c								
	ó	exec en ar rial-ti	EX	resulting in death) Last	Due to (or as	s a conseq	uence of):						
3	68760,	te be ysicia	edical		d								
Hom	89	tifica og ph as th											
,	Вох	eath cer ettendin for use	Physician/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			75-ti			- 1	23d. Date of deli-	very
		The law requires that the death cer site hes been signed by the ettendir bage 2 should be detached for use	10	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant a			⊒Ectopic pregnan ⊒ Other (specify)				Month	Day Year
3	P.0	t the by th	hys	9 🗆 Unknown	9□ Unknown								
LET COM		es tha gned be de	by P	Part II. Other significant conditions	contributing to death I	but not res	ulting in the u	inderlying cause g	pven in Part I.	23e. Did t	obacco	use contribute to	the cause of death?
	Ę	quire on sig uld b		Coroner,	intery,	1/4	cease			1 🗆	Yes 2	Pro 3□Pro	obably 4 □Unknown
\leq	Vital Records,	s been s s bould	Completed	Idy se tois	ie /					24a. Was		24b. Were au	topsy findings available
<	Re	The lav	E	-1900							rmed?	_ death?	ompletion of cause of
Ξ	ta			25. Was case referred to medical					26. Place of Dea	1 Yes		0 1 L Yes	2□ No
to purpletans	>	Physicien: this certific al director,	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	iont 2□	ER/Outpatier	nt 3 DOA O	ther			6 ☐Other (Spec	
Q	ō		5	27. Manner of Death	28a. Date of Inj. (Month, Da		28b. Time o		A STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STA	28d. Describe			ay)
$\vec{\Xi}$	o	th:	를	1 Matural 5 ☐ Pending 2 ☐ Accident investigat		ay Year)	Injury		ork? ⊒Yes 2⊡No				
	Division	r Attending ar death. rector: Atter by the fune	100	3 ☐ Suicide 6 ☐ Could not	289. Place of in	ijury - At ho	ome, farm, sti	reet, factory, office	9				ral Route Number,
1	Ö	P Star	Certification:	4 Homicide	building, e	tc. (Specif	y)			City or To	wn, Stat	(6)	
CROWN		Hospital 24 hours e Funeral (29a. Certifier 1 Certifying P	hysician: To the best	t of my kno	wledge, deat	h occurred at the	time, date and place	, and due to the	cause(s	s) and manner as	stated.
is in		To the Hos within 24 h To the Fun completely	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner s	of examina	tion and/or in	vestigation, in my	opinion, death occu	rred at the time,	date an	o place, and due	to the cause(s)
7		To the within 2 To the comple	Σ	29b. Signature and title of certifier	6/1)_ /	2 10-	29c. Licer	nse number		29d. Da	ate signed (Month	, Day, Year)
				Thur	7 1/1	el	cy MA	0	30496		1/	18/00	P
	1	0		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type,	Print)	1000			,	121701
		\ <u>`</u>		Mencis E.	Berker	Me	0.3	00 M	97/19	Pres	en	ck Ma	12/701
		Sta		31. Date filed (Month, Day, Year)		rar's Signa	H A	made					
		Registi	rar	JAN 2 2	2008	ne s	- 14p						

State of Maryland / Department of Health and Mental Hygien [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1420 P M Rev. Robert P. Hanlon, O.S.F.S. January 23 2008 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 Annecy Hall Childs If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□F Yrs. Director SEPT 22, 1923 207-14-4071 84 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "naturel", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Childs Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1120 Blue Ball Road 21916 United States Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? World 1 Myes 2□No If Yes, Give Year or Dates: War II Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 5+ Priest/Educator Religious traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William V. Hanlon Margaret Tompkins ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra Oblates of St. Francis de Sales 2200 Kentmere Parkway, Wilmington, DE 19806 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Depertment of H Important: If ite eny injury or of once. January 26, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oblate Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Childs, MD Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 21921 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 20 years **Physician** OSSTRICTIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? φ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2. No 1 ☐ Yes Certification; To 3 DOA 27. Manne Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 atural Injury 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, laclory, office building, etc. (Specify) 4 - Homicide Hospital 29a. Certifier 1 Confliging Physician: To the best of my knowledge, death conumed at the time, date and clane, and due to the nause(s) and channer as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (2-80055 ess of person who completed cause of death (Item 23a) (Type, Print) 412 Subarban Plaza hristine oral 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2008 FEB 04 Registrar

			1 - State Registrar C	partment of Health and Mer ertificate of Death	ntal Hygien	Z11118	02866
ı	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Clara Belle Hoffman	-	Date of Death Month Date of Death Nonth Date of Death	15, 2008	3. Time of Death 8 6:30 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	1
	Funeral		College View Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Frederick If Under 1 Year If Under 24 Hrs. 8.	Date of Birth	Freder:	ick place (State or Foreign
	Funeral Director		220-16-1006 1 M 20 F 89 Yrs.	Months Days Hours Min.	(Month Day Yea	1918 ^{co}	MD
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Ba-f et	ector	MD Frederick	Brunswick			1 XYes 2 ☐ No
	3a or 2	Dire	10e. Street and Number 1100 Peach Orchard Lane	10f. Zip Code 21716	10g. C	Citizen of What Cou US	
	teme 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	3. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Amer Black, White	ican Indian,
036	within 72 hours after death with the Maryland ene. then "natural", or Iteme 23e or 28e-f ehow he Madical Examiner must be notified at	þ	1 Never Married 2 Marned 1 Yes 2 No If Yes, Give 3 No If Yes, Or Dates:	1 ☐ Yes 2 X No Specify:		Specify: W	hite
5-0	n 72 ho "natur	eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G.	cedent's Usual Occupation ve kind of work done during most of working b. DO NOT use retired)	16b.	Kind of Business/li	ndustry
212	d withir jiene. r then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	homemaker	0	wn home	
Maryland 21215-0036	be file tal Hyg of othe event,	Be	17. Father's Name (First, Middle, Last) Franklin G. Norris	18. Mother's Name (F		en Sumame)	
aryk	should nd Mer marke umatic	70		Minnie Miling Address (Street and Number or Rural R		or Town, State, Zi	ip Code)21702
ž,	and 2 ealth a m 27 le		Walter Smith (Nephew) 853	O Edgewood Church	n Rd.,	Frederi	ck, MD
nore	ages 1 ant of H it: If Ite y or otl		cemetery, c	position (Name of rematory or other place) 1/18, the Valley Cemetery	2008 Mi	Location - City or T	own, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at 9058.		21. Sonature of Funeral Soviet Litensee	Bomandddrys of Firmompso P O Box 18, Middl	n Fune	ral Home	
			23a Part 1. Enter the disease, or complications that caused the death. Do not another than the disease, or complications are caused in each line.	-		IID ZI	Approximate Interval Between
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	opathy			Onset and Death
	Examiner		Due to (or as a consequence of):				
	ed sit	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury				
o,	cate be executed obysicien and the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	icate be physicia s the bu	dicai	d				
9 xo	h certifi anding use as	In/Me	IF FEMALE: 23b. Was decedent pregnant 1 □Live birth 2 □ Fetal death	2		23d. Date of deliv	/ery
Division of Vital Records, P.O. Box 6	Physicien: The law requires that the death certifics this certificate has been signed by the attending phrail director, page 2 should be detached for use as the	Physician/Med		3 Ectopic pregnancy 5 Other (specify)		Month	Day Year
S, G,	ss that t gned by se deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacco	use contribute to	the cause of death?
ord	require	eted	Chromic obstructive ful	many disray	1 🗆 Yes		bably 4 Unknown
Rec	fhe law te has l age 2 s	Completed			24a. Was an autopsy performed?	prior to c death?	opsy findings available ompletion of cause of
/ital	cien: 'ertifica ector, p	Be	25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)		
o d	Physi or this c eral dire	2	1 ☐ Yes 2 ☐ 1 ☐ Inpatient 2 ☐ ER/Outpat 27. Manngcof Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d	5 Residence		ify)
sion	Attending ir death. ector: After by the fune	cation	1 ☐ Natural 5 ☐ Pending (Month, Day Year) Injur 2 ☐ Accident investigation	y Work? M 1 ☐ Yes 2 ☐ No			
<u> </u>	or Att after d Direct J in by I	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f.	Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
	To the Hoepital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier (Check only 2 Medical Exeminer: On the basis of examination and/or	eath occurred at the time, date and place, and	I due to the cause	(s) and manner as	stated.
	othe Mithin 2 of the Foundation	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number		Date signed (Month	
1	->-0		Me Mo	D0060417	j	-15-	08
	7		30. Name and address of person who completed cause of death (Item 23a) (Tyg	boolouly be, Print) cas Johnson D	N FA	10 d o	21702 MB
	Sta	-	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	Sports on 12 and	7 7	COENTC	
	Registr	ar	JAN 2 2 2008				

Division or Vital Records, P.O. Box 68760

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Baltimore, Maryland 21215-00

To the Funeral Director: 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Dale signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) pup gistrar's Signature State JAN 23 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

lacksquare Baltimore, Maryland 21215-0036 ${\cal MC}$

Division or Vital Records, P.O. Box 68760,

		For State		State	of Marylar		artment of rtificate of			,		200	0 00	000
		Registrar 1. Decedent's Name	e (First Middl	e /act)		Ce	i lilicale oi	Deali	11	2. Date of De	Reg. No	-200	3. Time	O D O
Physicia	_		belle	Hurle	N 7					Month	Da		ear	
/Medic Examin	No.	4a. Facility Name (I					4b. City, Town,	or Location	n of Death	Januar	-	200 . County of I		7 a. ^M
LAGIIIII	-	Malla	rd Bay	Care Cer	nter		Cambi	ridge				Dorc	hester	
Funeral		5. Social Security N	lumber	6. Sex	7. Age (In yrs		If Under 1 Yea Months Days		er 24 Hrs. Min.	8. Date of Bir (Month, Da	th v. Year)	9.	Birthplace (State Country)	or Foreign
Director		213-22-5		1 M 2 K	8	0Yrs.		110010		July 2			Maryland	
and		Usual Residence of 10a. State	10b. County		10c. C	ity, Town or Lo	ocation						10d. Inside	City Limits
Mary f sho	jo	MD	Dore	chester			Camb	ridge					1 ∑X Ye	s 2 No
r 28a	irec	10e. Street and Nur	mber				10f. Zip Code			-	10g. Cit	tizen of Wha	at Country?	
th with	a D	906 O	akley '	Terrace			1	2161	3			USA		
r dea	Funeral Director	11. Marital Status			ecedent Ever in l Forces?	J.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic (Origin? (Spe	ecify Yes or No Rican, etc.))-		American Indian, White, etc.	
s afte	by Fi	1 ☐ Never Marr 3 ☐ Widowed		If Yes.	s 2 ⊠ No Give r Dates:		1 □ Yes 2 ☑ N	o Specii	ty:			Specify:	white	
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Men J Men Marke	2	Herber				1			azel !					
and 2 shealth and 2 27 is n		19a. Informant's Na Mark Hu		ship (<i>Type. Print)</i>	son		ng Address (Stree Red Phea						77040	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			☐ Cremation	3 ☐Removal fro	m State	cemetery, cre	osition (Name of ematory or other p		1	Date			ty or Town, State	
permit. P Departme Importani any injury once.		4 □ Donation 21. Signature of Fu			Ea		Market (2. Name and Add		cility	3/08 Omas Fu			Market,	_MD
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Physician /Medical		Immediate Cause of disease or condition resulting in death)	on	a. ///			- Sm	all (ell	CAN	er	`	Mo	1745
Examiner		Due to (or as a consequence of): Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of):												
outed d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.												
cate be executed physician and the burial-transit	al Exa	resulting in death)	Last	Due	to (or as a conse	quence of):								
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een s	ted	194	DETES	1 14	51.00	emil	1 17	y pec	Kasi	0121	Yes 2	2 □ No 3	obably 4	Unknown
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nding Path.	ation:	27. Manner of Dead 1 ☑ Natural 2 ☐ Accident	5 Pendi	/8	ate of Injury fonth, Day Year)	28b. Time Injury	W	jury at /ork? □ Yes 2	- 1	28d. Describe	how inju	ury occurred	l	
To the Hospital or Attending Physician: The law requires that the death certifuling 4 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could deterr	nined 200. Pl	ace of injury - At lilliding, etc. (Spec	home, farm, s	treet, factory, offic	e		28f. Location City or To			or Rural Route N	umber,
e Hospit 124 hour e Funera letely fille	Medical C	29a. Certifier (Check only one)	1 Certifyi 2 Medica	ng Physician: To I Examiner: On th and n	the best of my kr e basis of examination	nowledge, dea nation and/or i	ith occurred at the nvestigation, in m	time, date y opinion,	and place, death occur	and due to the red at the time	e cause(s	s) and mann nd place, an	ner as stated. d due to the caus	e(s)
To th withir To th	Me	29b. Signature and	title of certific	N	1-1	7.0.	29c. Lice	ense numbe	14 /	11	29d. Da	ate signed (Month, Day, Year)
5		30. Name ey add	4 /	who completed o	ause of death (Ite	em 23a) (Type		0 -	h/a		. 9	1/2	hil	
Sta	te	31. Date filed (Mior	nth. Dav. Year) 32	2. Restrar's Sign	nature	100	1014		21	6)	(172	n 10 120 Se	
Registr			JAN	3 2008	Acer	A	A SU							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			For State	State of Mary				Mental Hy	giene	00 0006
			Registrar		C	ertificate of	Death		Reg. No. 4	00 0700
46.0	Physici: /Medic		1. Decedent's Name (First, Middle, Last	Sylves	ter t	Haskin	5	2. Date of De Month	Day 15, 20	Year 3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give	11			or Location of Dea	th	4c County of	
		2	5. Social Security Number 6. Se	e Hous	yrs. last birthda		Ston If Under 24 Hrs	8. Date of Bi	rth Tal	
Ш	Funeral Director			M 2□F	/2 / Yrs.	Months Days			ay, Year) 28,1946	9. Birthplace (State or Foreign Country) Mary land
,			Usual Residence of Decedent		Ψ,			HIPTO	20,1772	•
L	yland how		10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits
Y	e Marts a-f s tified	cto	MD Talbo	+	Roya	1 Oak	<u> </u>			1 ☐ Yes 2 ☐ No
Q	er 28	Öjre	10e. Street and Number		1	10f. Zip Code	100		10g. Citizen of Wh	nat Country?
6	ath w	Funeral Director	6841 Belle	vue Ro	ad	1	662		US	American Indian
0	er de	nue	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever Armed Forces?	r in U.S.	B. Was Decedent of If Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue	Specify Yes of N rto Rican, etc.)	0- 14. Hade Black	- American Indian, , White, etc.
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	اخ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	10- 5-	1 ☐ Yes 2 ☑ No			Specify:	Black
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2121	within iene. than " he Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		aretal			Private	Residence
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Maryland	should be nd Mental marked o	To Be	James All	pert Ha	skins	5	Ann	a Ma	CKEV	
ar _y	2 shou and M Is mar aumat	-	19a. Informant's Name/Relationship (7				et and Number or I	Rural Route Num	ber, City or Town, S	State, Zip Code)
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ore	es 1 a of He ritem		20a. Method of Disposition 1 ■ Bunal 2 □ Cremation 3 □		20b. Place of Dis cemetery, c	position (Name of rematory or other pl	ace)	Date /	20c. Location - C	City or Town, State
Ĕ	Int.		4 □ Donation 5 □ Other (Specify		Royal Da	K Ceme	tery 11	19/08	Royal Od	ak. Maryland
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licen		?	22. Name and Add Henry F	ress of Facility	Home, P./	4. bridge, N	Naryland 2161
	7771		23a. Part . Enter the disease, or comp shock, or heart failure. List only of	lications that caused the	death. Do not	enter the mode of d	ving, such as cardi	ac or respiratory	arrest,	Approximate Interval Between
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1	/Medical		resulting in death)	a Due to (or as a co	onsequence of):	Ja Co	<u>. </u>			577703.
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P.O.	the d y the iched	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown						
	The law requires that the death certificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		Part II. Other significant conditions co	ontributing to death but n	ot resulting in the	underlying cause g	given in Part I.	23e. Did	I tobacco use contri	bute to the cause of death?
rds	w requires that s been signed I should be det	d b						. 10	Yes 2 No	3 Probably 4 ☐ Unknowr
00	aw rec	Completed by						24a. Wa	s an 24b. W	ere autopsy findings available
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>	Physician: r this certific ral director,	To B	examiner? 1 □ Yes 2 1 No	Hospital: 1 ☐ Inpatient	2 ER/Outpa	ient 3□ DOA	other: 4 \substack Nursing	Home 5 ☐ Re	sidence 6 Dothe	r (Specify) HOSPICE
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Division or Vital Records,	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc. (- At home, farm, Specify)	street, factory, offic	e		(Street and Number own, State)	er or Rural Route Number,
	urs al	Ce	Offic Cortifier 1 Continue 5th	ysician: To the best of n	ny knowledgo d	asth occurred at the	time date and pla	nce and due to th	in calleg(s) and ma	nner as stated
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	11		30. Name and address of person who	completed cause of deat	h (thom 22a) (Tu	o Print)	*	•		1

State

David H. Smith, M.D., 8221 Teal Drive, Ste. 302, Easton, MD 21601
31. Date filed (Month, Day, Year)

32. Registrar's Signature

33. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00621 State of Maryland / Department of Health and Mental Hygiene David Michael Kirsch, Sr Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day January 22, 2008 1445 hrs Medical Examiner DAVID MICHAEL KIRSCH, SR c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Howard Elkridge 5925 Setter Drive 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Months Davs Hours 10/06/1957 Country) MARYLAND Director 212-70-0696 1 **X**M 2 F 50 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 XYes 2 No ELKRIDGE HOWARD or 28a-f show MD must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21075 USA 5925 SETTER DRIVE 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married X Yes WHITE Specify: Give Year Yes 2 X No specify: Widowed 4 X Divorced item 27 is marked other than "natural", traumatic event, the Medical Examiner þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 } APPLIANCE REPAIR Baltimore, MD 21215-0036 2 APPLIANCE TECHNICIAN Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene ant: If item 27 is marked other than or other fraumatic event, the Medica 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY BLACK Be IRVIN KIRSCH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) OAK GROVE, KY 42262 341 PIONEER DR. DAVID MICHAEL KIRSCH, JR / SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 01/31/2008 EASTON, MD Department o
Important: |
injury or oth WOODLAWN MEMORIAL PARK Other Specify Donation 5 22 Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Signature of Fone Service Licenses 408 SOUTH LIBERTY STREET CENTREVILLE. 23a. Part I. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and failure. List only one cause on each line. Death Medical Atheosclerotic cardiovascular disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical XUNPENDED 4#23a,27,perME,g877 3/10/08 TT s been signed by the attending physician should be detached for use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy 23b. Was decedent pregnant in the Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed? death? Yes 2 V No he Hospital or Attending Physician: Th in 24 hours after death. he Funeral Director: After this certifical pletely filled in by the funeral director, pa 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 examiner? Other₄ Residence 6 Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural Yes 2 No Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 23, 2008 O.C.M.E. Com 30. Name and address of person who completed cause of death (Item 23a)

H₁₅

31. Date filed (Month, Day, Year)

JAN 2 9 2008 32. Figistrar's Signature

David Fowler M.D.

ignature Soul

111 Penn Street, Baltimore, MD 21201

Registrar

Chief Medical Examiner

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** HURRAY KISHTER 4:56 PM Longary 8006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Gen Burne If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Anne Arunda Baltimore Washington Medical 8. Date of Birth (Month, Day, Year) 12/20/1925 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) Kishter, Murray Baltimore, Maryland 21215-0036 5. Social Security Number **Funeral** 1 ₩ 2 □ F 217-22-5652 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 28a-f show at 1X Yes 2 □ No Director Palm Beach West Palm Beach 10g. Citizen of What Country? 10e. Street and Number 0 5294 Tiffany Anne Circle 33417 'natural', or Items 23a United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Jewelry Designer Jewelry is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Irving Kishter Rose Fastoff 2 of Health and Mitem 27 is mail other traumal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiffany Anne Circle West Palm Beach FL 33417 Adele Y. Kishter - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages t Department of H Important: If ite any Injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of Remembrance 1/17/08 Clarksburg, Memorial Park

Danial Park

Danial Remembrance 1/17/08 Clarksburg, Memorial Chapels 2 Inspection of the Rockville Pike Rockville MD 20852 Clarksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ZITIJOS SIMBUSZĪ 3 MEEKS /Medical Due to (or as a consequence of) Examiner 20 YEARS 3243211 AAJUSZAU JAASH91A39 BABUBZ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760, aftending physician for use as the buriz Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. 1 signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ■ Unknown DIABETES, PACEMAKER PLACEMENT 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an has autopsy performed? certificate 2 No. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OH , way grain sect modelie 3 D0065 F1A BOOL IT PAAUMAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

CUILLERMO JOSÉ CIMPRECO

32. Registrar's Signature

31. Date filed (Month, Day, Year)

301 HOSPITAL DRIVE, GLEH BURHIE, MD 20161

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Winifred Maxine Leydorf P^{M} 15, January 2008 3:32 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Months Days 019-22-5318 89 Ohio April 18, 1918 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Anne Arundel Annapolis Maryland 1 ☐ Yes XXNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4223 River Crescent Drive 21401 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼No Specify White Specific 3℃Vidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luetta Linkhart Mathias Vogelpohl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 909 Echo Bay Court Gambrills, Maryland 21054 Glenn C. Leydorf/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park 1/21/2008 Glen Burnie, Maryland 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licenses 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ere days disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9□ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? arkinsons sease 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy

Physician /Medical Examiner

Department of Health ar Important: If item 27 Is any Injury or other traconce.

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

items

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Inter or Health and State of the than "natural", or ite inter than the traumatic event, the Medical Examinearly or other traumatic event, the Medical Examinearly.

than the M

Baltimore, Maryland 21215-0036

Examiner

Director

Funeral

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Completed

Be

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death with the Maryland

Examine Completed by Physician/Medical the as attending use for ed by the a page 2 has this certificate Be After within 24 hours after death.

To the Funeral Director: Aft

The law requires that the death certificate be executed

or Attending Physician:

Division or Vital Records, P.O. Box 68760.

25. Was case referred to medical examiner? 27. Manner Death

1 ☐ Yes

1 Natural

200

29b. Signature and title of certifier

Certification: To

Medical

State

5 ☐ Pending investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

1 Dinpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28h. Time of

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30 Name of person who completed cause of death (Item 200) (Type, Print 31. Date filed (Month, nevo

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 9:20 P M January 11, 2008 James Christopher Lenox /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Crofton Anne Arundel 1108 Moderno Ct. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, Year) 1/02/1954 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Washington, DC Director 216-60-1183 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23 aor 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Director Crofton Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21114 USA 1108 Moderno Ct. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Gas Line Repairman Washington Gas 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Robinson Joseph James Lenox 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crofton, MD 21114 Sharon S. Lenox/ Wife 1108 Moderno Ct., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 □ Cremation 3 □ Removal from State Our Lady of Sorrows 1/19/08 West River, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatus Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ancer **Physician** . 5 Year /Medical Due to (or as a cons uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): attending physician for use as the hirria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 certificate or Attending Physician; 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time. 29a. Certifier

Division or Vital Records, P.O. Box 68760, completely filled in by the funeral To the Hospital within 24 hours a

Registrar

Medical

31. Date filed (Month, Day, Year) 2008 **JAN 16**

29b. Signature and title of certifier

305 Hospit Markan 32. Resistrar's Signature

on 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D39505

Dr. Glan Rumie, MD.

29d. Date signed (Month, Day, Year)

14,2008

			For State Registrar		State	of Maryl	and / [-	nent of H cate of I		nd Men		ene g. No. 2	008	028	74
£		Щ	Decedent's Name (First,	Middle, Las	,							Date of Death Month		Year	3. Time of Dea	
	Physicia /Medic		Dorothy								Ja	Month inuary		2008	3:35 a.	. M
	Examin	er	4a. Facility Name (If not ins Mallard					4b.	City, Town, or	Location of D bridge			4c. Cou	nty of Deat Dorch	ester	
	Funeral		5. Social Security Number	6. S		7. Age (In	yrs. last bii		Inder 1 Year	If Under 24	1 Hrs. 8.	Date of Birth	Venel		hplace (State or Fountry)	reign
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3	3a or	Funeral Director	602 Water	Stree	et				2	1613				USA		
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land	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show taumatic event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, I								•	irst, Middle, M	laiden Sur	name)		
<u>X</u>	ould to	2	Henry Llo				100	- Basilina Ad	dress (Street			Villey	City or To	wa State	Zin Coda)	
Mai	d 2 sh th and 7 Is n traun		19a. Informant's Name/Re Ann Webste			aughtei			odd Pc						613	*
رة م	Heal tem 2		20a. Method of Disposition						(Name of ry or other place		Date				Town, State	
altimor	Pages ent of nt; If i		1 🖾 Burial 2 □ Crem 4 □ Donation 5 □ C			n State	_	· -	erans	1	1/22/	/08	Hur]	lock,	MD	
Balti	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic enone.		21. Signature of Funeral S	Service Lice	nsee				me and Addre		THOU	nas Fur		Home 21613		
			23a. Part1. Enter the dise shock, or heart failur	ase, or com	plications that	t caused the	death. Do	not enter the	Locus mode of dyir	ng, such as ca	ardiac or re	espiratory arre	est,	21013	Approximate Interval Betwee	n.
	Physician	V 7	shock, or heart failur Immediate Cause (Final disease or condition	re. List only	one cause or	Meta	Stal	he	over	ian	Ca	weer			Onset and Deat	th
	/Medical		resulting in death)	-	и.	o (or as a co										
	Examiner	L	Sequentially list conditions	s. I	b											
	ed sit	iner	Sequentially list conditions if any, leading to immedia cause. Emer Unioning Cause (Disease or injury that initiated events	te 🕹	Due t	o (or as a co	nsequence	of):								
Б	xecut and	Examin	that initiated events resulting in death) Last		c	o (or as a co	nsequence	of):								
8/60	The law requires that the death certificate be executed the has been signed by the attending physician and otge 2 should be detached for use as the burial-transit	dical E		l	d											
200	tificating phy as the	ledi											-			
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	ne dea the at hed fo	/sìci	in the past 12 month 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	5:	4□Pre 9□Unl	egnant at time known	of death	5 ☐ Oth	er (specify) _	-	-					
7.	that the	Phy	Part II. Other significant	conditions	contributing to	death but no	t resulting	in the underl	ying cause giv	ven in Part I.		23e. Did tob	acco use	contribute to	o the cause of deat	h?
Vital Records,	uires l signe	d by										1 □ Y€	es 2 PK	lo 3□P	robably 4 ∐Unk	nown
Ö	w req	Completed										24a. Was a		4b. Were a	utopsy findings ava	ilable
¥ Y	The lay te has age 2	фшо				-						autops perforr 1∐ Yes	ned? 2.☑No	prior to death? 1 ☐ Yes	completion of caus	e or
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	Physic this ce al direc	70 E	1 ☐ Yes 2 ☐ №6			-		utpatient 3	DOA			5 ☐ Reside			ecify)	
Division or	ling P After t funers	inol		Pending	(M	te of Injury onth, Day Ye		Time of Injury	28c. Inju Wo 1	ryat rk?]Yes 2∐N		d. Describe ho	ow injury or	ccurred		
<u>s</u>	death death ctor: y the	icat	0 0 0 0 0 0 0 0 0 0	investigatio	28e. Pla	ace of injury -	At home,		factory, office			. Location (St	reet and N	umber or R	ural Route Number	r,
2	al or A after I Dire d in b	Certification:	4 🗍 Homicide	determined	bu	ilding, etc. (S	Specify)					City or Towi	n, State)			
	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ertifying P Medical Exa		the best of me basis of exa anner stated.	amination a	ge, death occ and/or invest	curred at the tigation, in my	ime, date and opinion, deat	d place, and th occurred	d due to the c at the time, d	ause(s) an late and pla	d manner a ace, and du	s stated. e to the cause(s)	
	ro the vithin ro	Med	29b. Signature and title of	f certifier	1.0				29c. Licens	se number		2			th, Day, Year)	
	- > - 0		•	July	1 -	10			1)4	792	4		1-1	8-0	8	
r			30. Name and address of	person who		ause of death	(Item 23a		7 (ANGRI	RIDE	W 3	70	216	/3	
	Sta	ate	31. Date filed (Month, Day	y, Year)	32	Registrar's				·						
	Regist	rar	JAN	2 2 2	UU8	The same	1	Ass.	S							

DHMH 17 Rev 1/2001

ORIGINAL

Division or Vital Records, P.O. Box 68760,

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

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Squi:	-uneral Director: After this certificate has been signer by the attending physician and	ely filled in by the funeral director, page 2 should be cetached for use as the burial-transit	cal Certification: To Be Completed by Dhyelcian/Medical Evaminer
Tions allet dealls.	neral Director: A	filled in by the fu	Cortificati
-	ë	ek	5

Physician

/Medical

Examiner

Funeral

Director

show É 28a-f sh notified

7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r

Department of Health a Important: If item 27 is any Injury or other trainonce.

Physician

death with the

Pages 1 and 2 should be filed within 72 hours after

and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

à

Completed

Be

/Medical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Tes 27. Manner of Death ear) Injury Mo 5 Pending investigation NA 1 Tes 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At hon building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of Artifier 00064568

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 1-28-08

MAINIV

30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) DECHUSA

Brunswick, MD

State Registrar 31. Date filed (Month, Day, Year) FEB 04 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 13,2008ea **Physician** McClaren Wesley J. 5:25ptM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Atria- Manresa Annapolis Birthplace (State or Foreign
 Montry) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 5. Social Security Number 6. Sex **Funeral** 4*M227*3921 487-28-0303 1**X** M 2 □ F 86 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No MD Anne Arundel Annapolis Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1040 Lake Claire Dr. 21409 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ¼Yes 2 □ No 1945 — If Yes, Give Year or Dates: 1972 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married White 1 ☐ Yes 2€XNo þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) US Navy Captain 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leatha L. Honaker Wesley James McClaren 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1040 Lake Claire Dr. Annapolis, MD 21409 19a. Informant's Name/Relationship (Type. Print) 1040 Lake Claire Dr. Anne McClaren Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 1/15/2008 Baltimore, MD Metro Crematory 21. Signalare of Fune at Service censee 22. Name and Address of FacilityHardesty Funeral Home, P.A. 170 0 Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEIRE Due to (or as a consequence of) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown MITRIA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2√2No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient မ 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury

1 ☐ Yes 2 ☐ No

1 Accrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

attending physician for use as the buria After t

Division or Vital Records, P.O. Box 68760,

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
completely filled in by the

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Caputo 139 Old Solomons Island Rd. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 Natural

2 Accident

3 Suicide

29a, Certifier

Medical

4 Homicide

Annapolis, MD 21401 32. gistrar's Signature

ORIGINAL

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

JAN 17 2008

5 Pending investigation

6 Could not be determined

			1 → For State Registrar	State of Maryl	-	artment of F rtificate of			iene 0 0 8	8 02877
P	nysicia		Decedent's Name (First, Middle, Las					2. Date of Deat Month	Day Y	3. Time of Death
15.7	Medic		Robert McCune			41. O'b. T	1 6 10 11	January	4c. County of	008 03:48 M
E	xamin	er	4a. Facility Name (If not institution, give Montgomery Gene)			4b. City, Town, o	r Location of Death		Montgo	
	300	-	5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9	Birthplace (State or Foreign
	neral ector		183-12-4535	X M 2□F 8		Months Days	Hours Min.	(Month, Day, Mar. 28	rear)	Pennsylvania
and			Usual Residence of Decedent 10a. State 10b. County	10c	City, Town or Lo	cation				10d. Inside City Limits
Maryl	a pei	to	Md. Montgo	omery	Gaith	ersburg				1 □ Yes 2 X No
the sec	Tiger I	rec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	at Country?
h with	ad he	a D	20920 Delta Dri	ve			20882		United	l States
21215-0036 Solve within 72 hours after death with the Maryland gignen. An analyzed for leave 33a or 28a-1 ahow	event, the Madical Examinst must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hilf Yes, specify Cuba 1 ☐ Yes 2 🛣 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		American Indian, White, etc. White
2- Po	ical i	Completed	15. Decedent's Ed (Specify only highest grad	ucation		dent's Usual Occup	pation during most of work	cina	16b. Kind of Busi	ness/Industry
Marie 1	Mac	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	9	77 C Cc	
N pos	4		12	2	Buc	lget Anal		o (First Middle)	U. S. GC Maiden Sumame)	overnment
Maryland 2121 nd 2 should be filed within th and Mental Hygiene.	tic eve	To Be	17. Father's Name (First, Middle, Last) Chalmers P.	Means			Eliza		icCune	
Mary and 2 sho alth and	r traum		19a. Informant's Name/Relationship (7 Elizabeth M. Mea		19b. Maili 2092	ng Address <i>(Street</i> 10 Delta l	and Number or Rui Drive, Ga	al Route Number ithersbu	r, City or Town, St Irg, Md.	ate, Zip Code) 20882
Baltimore, Department of Hear	ry or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State		osition (Name of matory or other place itan Crei	ce)	Date 9/08	20c. Location - Ci	ity or Town, State dria, Va.
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta models. If them 27 is marked.	any inju		21. Signature of Funeral Service Licen		her	Name and Addre Muriel P. O.	ss of Facility H. Barber Box 5038,	Funeral Laytons	Home ville, N	1d. 20882
Phys	ician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	olications that caused the cone cause on each line.	v	ter the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
760, Ite be executed weight and and and and and and and and and and	e burial-transit	Ical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to (or as a cor Due to (or as a cor Due to (or as a cor d.	isequence of):					
Box 64	detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnance □ Other (specify)	у		23d. Date Monti	,
ds, P.	ا ۾ ھ	by	Part II. Other significant conditions on MYOCAR DIAC			inderlying cause giv	ven in Part I.			oute to the cause of death?
	9 2	Completed						24a. Was a autops perfor	sy pri med? de	ere autopsy findings available or to completion of cause of ath? Yes 2 \[\sum \text{No} \]
tal 	- i	0	25. Was case referred to medical				26. Place of Dea	th (Check only or		1103 20110
of Vita	2 E	To B	examiner?	Hospital:	2 ER/Outpatie	nt 3 DOA Ott	200		ence 6 Other	(Specify)
On O	neral		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	Wo	ry at rk?]Yes 2 □ No	28d. Describe h	ow injury occurred	d
Division To the Hospital or Attending within 24 hours after death.	d in by the	Certification:	3 Suicide 6 Could not be determined			reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
Mospital 24 hours a	etely fills	edical C	29a. Certifier 1 Certifying Ph	ysician: To the best of my niner: On the basis of exa and manner stated.	knowledge, dea mination and/or ir	th occurred at the ti evestigation, in my	me, date and place opinion, death occur	, and due to the c rred at the time, c	ause(s) and mani date and place, ar	ner as stated. nd due to the cause(s)
To the	compl	Me	29b. Signature and title of certifier	1/		29c. Licens			i 1	(Month, Day, Year)
20+1			30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)	0 45661	0100-	1/18/3	20832
	Sta legistr		Delsorah Ste 31. Date filed (Month, Day, Year)	completed cause of death 20, 20, 181	Signature	Scarle)	1		7,	

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Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran. Division or Vital Records, P.O. Box 68760,

1 - State Registrar Certificate of Death Reg. No. 2008 0287								
ian	1. Decedent's Name (First, Middle, Last)			2. Date of Deat Month	Day	Year	3. Time of Death	
cal	Paul Medford Newcomb				January		008	1:15 a. ^M
ner	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County	of Death	
**	4131 Maple Dam Road 5. Social Security Number 6. Sex 7. Age (In vrs.	/ 4 b 2-46 -/	Cambr If Under 1 Year		Tab. (Bill	I		ester
	220-12-0804	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 16		Cour	place (State or Foreign ntry) ryland
	Usual Residence of Decedent 10a, State 10b, County 10c, City	v. Town or Loc	eation				1	0d. Inside City Limits
ctor	MD Dorchester		Ca	mbridge				1 ☐ Yes 2√ No
Funeral Director	10e. Street and Number 4131 Maple Dam Road		10f. Zip Code	21613	10	g. Citizen of \	What Cour JSA	ntry?
nei	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. W	/as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-		e - Americ	
	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		□Yes 2DXNo	Specify:	, , , , , , , ,	Specify		
Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decede (Give k	ent's Usual Occupa aind of work done of ONOT use retired	ation furing most of work)	king	6b. Kind of Bu	usiness/Ind	dustry
E	Elementary/Secondary (0-12) College (1-4or 5+)	stat	ionary e	ngineer		ho	spita	al
BeC	17. Father's Name (First, Middle, Last)	<u> </u>		18. Mother's Nam	e (First, Middle, N			-
To E	George Medford Newcomb			Vivian	Fitzhugh	1		
,	19a. Informant's Name/Relationship (Type. Print)		Address (Street a				State, Zip	Code)
	Sara Smith daughter 20a. Method of Disposition 20b. P	1	Maple Dition (Name of			ge, MD	2161	
	1 ☑Burial 2 ☐Cremation 3 ☐Removal from State	emetery, crem	atory or other place. Mem. Pa	e) ¦		Cambri	•	
	21. Signature of Funeral Service Licensee		Name and Address OO Locus	11	nomas Fur	eral H		
	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.						1013	Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	Azr	Lyth	WIA				Onset and Death
	Due to (or as a consequ	Arten	Disen.	57				1645
miner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Proku	serin	•				1647
Medical Examiner	resulting in death) Last Due to (or as a consequence)	ence of):						,
edic	d							
Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 🗆	Ectopic pregnancy Other (specify)				te of delive	ery Day Year
by Ph	Part II. Other significant conditions contributing to death but not resu	llting in the und	derlying cause give	n in Part I.		_		ne cause of death?
eted					1 □ Ye			ably 4 Unknown
Comp					24a. Was an autopsy perform	ed?	death?	psy findings available inpletion of cause of 2 No
Be	25. Was case referred to medical examiner?		101	26. Place of Deat	h (Check only one)		
7	THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE S	R/Outpatient		4 Nursing Ho	me 5 Resider			y)
tion	27. Manner of Death 1	28b. Time of Injury	28c. Injury Work M 1 □ Y	at ? ′es 2 □ No	28d. Describe how	v injury occurr	ed	
ertifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At homicide certained 5 ☐ Could not be determined 28e. Place of injury - At homicide building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Numb State)	er or Rura	I Route Number,
Medical Certification:	29a. Certifier (Check only one) Certifying Physician: To the best of my know 2 ☐ Medical Examiner: On the basis of examinat and manner stated.	vledge, death ion and/or inve	occurred at the timestigation, in my op	e, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and ma te and place,	inner as st and due to	tated. the cause(s)
Me	29b. Signature and title of certifler		29c. License			d. Date signed		
	Myfolden		126	388	J.	M 23	3 20	20 g
	30. Name and address of person who completed cause of death (Item Michael Facility Ms	23a) (Type, P	D26	c Hurlo	ck Mc	9 21	64	3
te ar	31. Date filed (Month, Day, Year) 32. Refistrar's Signat	ure	and a		,			

State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1/13/2008 Rolf-Dietrich Owe 6:15am™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spa Creek Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Ye 5/2/1927 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 F 80 110-28-4266 Director Germany Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD Anne Arundel Annapolis 1 ☐ Yes & No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 930 Bay Forest Ct. 21403 A - 1111USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 🔀 No Specify: White Specify: Ś 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. 12 Machinist Cutlery 27 Is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Richard Johann Owe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I 8483 Kings Meade Way Columbia, MD 21046 Manfred Owe Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 IC Cremation 3 ☐ Removal from State 1/15/2008 Metro Crematory Baltimore, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Anna 22. Name and Address of Facility Hardesty Funeral Home, P.A. 70 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiac Arythmia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to Immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical attending I 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 □ Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐ Yes 2 🔀 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failure to thrive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No မ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Nettical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1/14/2008 D57028 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aditya Chopra, M.D. 600 Ridgely Ave. #231 Annapolis, MD 21401 31. Date filed (Month, Day, Year)

State Registrar

7 2008 JAN 1

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

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ife, Maryland Z1Z13-UU30 1 and 2 should be filed within 72 hours after death with the Marylar f Health and Mental Hygiene. Item 27 ie marked other then "naturel", or items 23e or 28a-f ehow other treumatic event, the Medical Exertition market by notified at		19a. Informant's Name/Relationship										Town, State, Z		
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10		30 Name and address of person who	completed cause of	death (Item :	23а) (Туре.	Print)	11	~#1	04 F	Todo.	id	MI	2171	
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Known to physiciance: Grace Petligrum

TOD 2310

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** GERALDINE FRANCES ROTOLONE $J_{\text{anuary}}^{\text{Month}}$, 2008 7:30 Рм /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Heartfields at Frederick Frederick Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan. 5, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛭 F Illinois 345-24-3566 Jan. Director 78 1930 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Frederick Frederick 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 1820 Latham Road U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever în U.S. Armed Forces? 14. Race - American Indian, 11, Maritai Status Black, White, etc. 1 ☐ Yes 2**X** No if Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Truex Margaret Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a Jeff Rototone / Son 1731 Algonquin Road, Frederick, Maryland 21701 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory 1/18/08 Smithsburg, Maryland 4 Donation 5 Other (Specify) 21. Signatury of Mineral Ser ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 e, or complice. List only on he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (as a consequence of): disease or condition resulting in death) 4 month CONCRY /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed use as the burial-tran and Due to (or as a consequence of): P.O. Box 68760. attending physician I for use as the bunis Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month Year signed by the at d be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a Was an autopsy performed? 1□ Yes 2X No certificate 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence ASSISHED Hospital: 2**X** No 3 DOA 2 1 Tyes 1 Inpatient 2 ER/Outpatient 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred FAULIA Certification: After Hospital or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

29b. Signature

30. Name and

29c. License number

Fredorick no

29d. Date signed (Month, Day, Year)

and manner stated.

ress of person who completed cause of death (item 23a) (Type, Print)

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Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Agnes **Physician** Boi Sheriff Year 11:31pM 2008 January 12, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5506 Western Avenue Montgomery Chevy Chase 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 577-21-8328 1 M 2000 49yrs Director Sierra Leone 4/12/58 Usual Residence of Decedent death with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at MD Montgomery Silver Spring 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 20901 10g. Citizen of What Country? 3 Manchester Place United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★★No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: African <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 2yrs is marked other than Elementary/Secondary (0-12) Health T.PN or other traumatic event, permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Koligo Mossima Ballay Kamara 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bashirr Sheriff (spouse) 3 Manchester Place, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) unk. Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 X Removal from State Sierra Leone d 4 ☐ Donation 5 ☐ Other (Specify) Mokondeh Village Cem. 22. Name and Address of Facility McGuire Funeral Service, 21. Signature of Funeral Service Licenses nolle 7400 Georgia Avenue, NW, Washington DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** roba MG /Medical Due to (or as a consequence of): Examiner Jensive Securitielly list or divine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
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9 Unknown Day Year 5 ☐ Other (specify) ed by the a detached f P.0. 9□Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Records, ģ 2 No 1 Tes 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page perform certificate Vital 1 Physician: rector, 25. Was case referred to medical Be 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 2 1 🔲 Inpatient Division or 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

State Registrar 29b. Signature and title of certific

31. Date filed (Month, Day, Year) JAN 18

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DHMH 17 Rev 1/2001

29c. License number

2101 metical

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MKECH

2008

m DMC

egistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:30 pm^M January 13,2008 Snowberger Μ. Marian /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Crownsville Anne Arundel 660 Old Herald Harbor Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 90 Hours 1 □ M 2 🕅 F Virginia Oct 18,1917 Director 218-09-1146 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10c. City. Town or Location 10b. County 1 ☐ Yes 2 No Crownsville MD Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code an "natural", or items 23a or Medical Examiner must be 21032 USA 660 Old Herald Harbor Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2**X X**No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🏋 No White Specify: Completed by 3 Wildowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "n any injury or other traumatic event, the Media once. the M Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 Hallie Mae Thompson Alfred Marion Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 660 Old Herald Harbor Rd. Crownsville, MD 21032 Daniel Snowberger Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/18/2008 Glen Haven Cemetery Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 77 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIA **Physician** /Medical Due to (or as a consequence of): **Examiner** ONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (b) as a consequence of Examine be executed HYPERTENSION burial-tran and Due to (or as a consequence of): P.O. Box 68760 physician DIABETES Physician/Medical as the l IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No DR TER 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 1□ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this funeral 27. Manner of Ceath 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day , Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🔭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely

State Registrar

within 2.

29b. Signature and title of certifier

8028

DHMH 17 Rev 1/2001

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29c. License number

PASMOENA

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LTCALE

31. Date filed (Month, Day, Year) 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 7:10A M Liane Lucie Schutz JANUARY 15 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctor's Community Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 X F 28, Germany Director 220-56-5130 70 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No Directo Maryland Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20715 12106 Wilmont Turn USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Alfred Uhlemann Honi Lorenz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1415 Kinghaven Court Gambrills, MD 21054 Deirdre Smee/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart Catholic 1/19/2008 Bowie, MD 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Carcinoma **Physician** 2 2 x Lung disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 90 40000 Sequentially list conditions, it any constitution of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Otner (specify) ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Trover 1 TYes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has birector, page 2 s drease 1□ Yes 2 **1**No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No ဥ 3□ DOA this : After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Hospital or Attending 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

r's Signature

Registrar

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Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 0940 M William Francis Simpson, Jr. 01 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 12 M 2 ☐ F Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 579-48-8812 86 07/03/1921 Director Washington, D.C. Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 Xes 2 □ No Directo Maryland | Prince George's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20716 U.S.A. 14997 Health Center #257 Funeral 12. Was Decedent Ever in U.S. Armed Forces? YZYes 2☐ No If Yes, Give Year or Dates: 146-148 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes XXX Specify Specify: Completed by 3 ☐XXXdowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Health Care Physician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Menta Anita T. Orlando William F. Simpson, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any injury or other trau 2796 Spring Lakes Drive, Davidsonville, Md 21035 David M. Simpson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Silver Spring, Maryland Gate of Heaven 01/15/2008 4 Donation 5 Dother (Specify) 21. Signature of meral Service Robert E. Evans Funeral Home 22. Name and Address of Facility 1 16000 Annapolis Road, Bowie, Maryland 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of 3 1 Examiner TCU TE INFARCTION D CARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner CARDIN VASCULAR DISPASÍ requires that the death certificate be executed burial-transi 47+80205C MOTIC that initiated events and resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 t certificate has autopsy performed? Yes 2 No death? 1 ☐ Yes 2 □ No or Vital Physician: After this certification funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 **S**npatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 21438 11,4008 0. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOUS MD 31. Date filed (Month, Day, 32. Reastrar's Signature Year State JAN 1 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 5:30 P M 9 2008 Harrison Spriggs January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center <u>Annapolis</u> <u>Anne Arundel</u> If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Ye July 16 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6 1916 **Funeral** Days 1√2 M 2□ F 214-14-4993 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ⊈Yes 2 □ No Maryland Anne Arundel Annapolis Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2091 Forest Dr. 21401 USA Funeral 14 Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 M Yes 2 □ No If Yes, Give Year or Dates: 1957-61 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Brick Mason 7th 0 Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Spriggs P Mary Unobtainable 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth E. Spriggs(Wife) 2091 Forest Dr. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 1-16-08 Crownsville, Md. 4 Donation 5 Dother (Specify) Manual Recognitions Mortuary, P.A. 21. Signature of Funeral Service Licenses Javry J. Rese MSO483

23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause in such line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death t enter the mode of dying, such as cardinc or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** morr /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or identifying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of) Physician/Medical as the t IF FEMALE for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed been 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate has autopsy 1□ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dipatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Natural 5 Pending investigation ithin 24 hours after death.

o the Funeral Director: A
ompletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier соmpletely and manner stated. 29b. Signature and title of Pertifier 29c. License number 29d. Date \$igned (Month, Pay, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) e ,

State Registrar 31. Date filed (Month, Day, Year)

JAN 1

2008

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Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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VISION	endlr ath. or: Af he fur	atio	2 ☐ Accident inves	stigation	, 54.7	M		res 2□N	No				
Ĭ	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	rmined 28e. Place of inju- building, etc	iry - At home, f c. <i>(Specify)</i>	arm, street, factor	y, office		28	3f. Location (Stre City or Town,	et and N State)	umber or Run	al Route Number,
_	spital ours a neral I		29a. Certifier 1 Certify	ying Physician: To the best	of my knowledg	e. death occurred	I at the tim	ne. date an	d place, ar	nd due to the cau	ıse(s) an	d manner as s	stated.
	n 24 h n 24 h ne Fur	edical		al Examiner: On the basis of and manner sta	examination a								
	To tl withi To tl comp	Me	29b. Signature and title of certif		20 1	11.	c. License	_	,,			igned (Month,	
)	-1		you	~ 7//S	Ell	177	[]3	09	196		1/1	18/2	008
	18		30. Name and address of person	on who completed cause of d	eath (Item 23a)	(Type, Print)	1. 97.	717	12	cherale	M	1215	701
	Sta Registr		31. Date filed (Month, Day, Yea JAN 2	2 2008 32 legistra	ar's Signature	Apartis)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Vear January 16 2008 12:20p. Laura Jane Schap /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Deer's Head Center Wicomico Salisbury If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days 1 □ M 2 1 × F 209-22-5324 80 Director June 30, 1927 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Wicomico Director 1 □ Yes 2 NO Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6172 Ayrshire Drive 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No white þ Specify: 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nurse hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Hijav Marie unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Attison Barnes 28230 Connelly Point Rd, Trappe, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Dorchester Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 1/21/08 Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee Bik. 72 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) pneumonia Due to (or as a consequence of): persistent urinary tract infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner death certificate be executed

or 28a-f shov must be notified at

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permit. Pages 1 and 2: Department of Health a Important: if Item 27 is a ry injury or other traugities.

Pages 1 and 2 should be nent of Health and Mental

traumatic event, the Medical Examiner

Baltimore, Maryland 21215-0036

physician and s the burial-transit attending ph signed by the page rector. this

in by 1

Medical

death. the within 24 hours after death To the Funeral Director:

Division or Vital Records, P.O. Box 68760

or Attending Physician:

4 Homicide

29a. Certifier (Check only one)

29b. Signature and titls of certifier

determined

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

H66064

29d. Date signed (Month, Day, Year)

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)
TONY GONSALVES, D.O. DEERS HEAD HOSPITAL CENTER

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1- State Amend PI line a-c, 25, perME, g877 3//68rtificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Augustine Saldana 2008 20:20 13 JANVARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sausbury MD f Under 1 Year J J Under 24 Hrs. Regional Medical Ce Peninsula)ICOMICO 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 XM 2 ☐ F None 42 April 24,1965 Director Mexico Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatih and Mental Hyglene. Inst. If Item 27 is marked other than "natural", or items 23a or 28a-f show mit. If Item 27 is marked other than "natural", or items 23a or 28a-f show my or other traumatic event, the Medical Examiner must be notified at my or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 523 Winder Street, Apt. A 21801 Mexico Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1KD Yes 2□ No Completed by Specify: Mexican White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Susano Saldana ၉ Patricia Nava 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a ltem 27 I Sister Agnes Oman/Friend 418 Wicomico Street, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages Department of I Important: If Its any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/16/2008 4 Donation 7 5 Other (Specify) Crematory of Delmarva Delmar, Delaware Zeller Funeral Home, P. 0. 1212 Old Ocean City Road, 21. Signature of Funeral Service Licens MD 21802 Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Complications of antituberculosis treatment** Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Examiner MCATION APPROVED BY MEDICAL EXAM The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): ಳ ಹಿ ಗ್ರಾನ್ಸ್ Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t irector, page 2 s autopsy performed? To the Hospital or Attending Physician: within 24 hours after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 XX es em N Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 1 Inpatient this 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L 29a Certifier 1 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brett HOFMANN 100 E. Carroll St. Salisbury 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla		artment of			201	38	02892
			Decedent's Name (First, Middle, Last)				. 200	2. Date of De	Reg. No.		3. Time of Death
	Physici		Richard Jerman	Sockriter,	Jr.			Jan.	15 20	Year 008	6:11PM M
	/Medic Examir		4a. Facility Name (If not institution, give :		011	4b. City, Town	, or Location of		4c. County	0.11111	
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	Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Yea	ar If Under 24	4 Hrs. 8. Date of Bir			
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\sim	sho	5	Maryland Wicomico	100.							10d. Inside City Limits 1 ☐XYes 2 ☐ No
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2	with a or	ក់			1 /	10f. Zip Code			10g. Citizen of		ntry?
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<u>ya</u>	Ment Ment arkac	은	Richard Jerman So	ckriter, Sr.	•		Li1	lie Mae No	rman		
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ţ	t. Partmentant:		4 □ Donation 5 □ Other (Specify)	Cr	ematory c		-	17/2008	Delmar,	Del:	aware
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×	eath certifi ettending for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pre	gnancy				224 00	40 04 dalis	
Box	The law requires thet the death certifi tie has been signed by the ettending aga 2 should be detached for use as	by Physician/Me	in the past 12 months?	1 Live birth 2 □ F 4 □ Pregnant at time of	etal death 3[Ectopic pregnar Other (specify)	псу			te of delive onth	Day Year
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Vital Records,	quires in sign uld be	g pa						10	Yes 2□No	3 Prot	bably 4 nknown
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ta		0	25. Was case referred to medical				26 Place o	1 ☐ Yes If Death Check on c		1 🗌 Yes	2∐ No
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Division of	r Att	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str	eet, factory, offic	е	28f. Location (. City or Toi	Street and Numb	er or Rura	al Route Number,
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	To the Hospital or Attendi within 24 hours after death To the Funeral Director; A completely filled in by the fo	Medicai	29b. Signature and title of celtifier	and manner stated.			nse number				
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	Λ		20 Name and different			1	2017)	11101	20	
	N		30. Name and address of person who co	npleted cause of death (I	1	C.L	Sala	bus w	ν ^(γ)	dina	51
	Sta	te.	31. Date filed (Month, Day, Year)	32. Resistrar's Si	gnature	2.1.	- 4/10	, 10	0	2180	J!
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DHMH 17 Rev 1/2001

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T	Physici		1. Decedent's Name (First, Middle, La	st)							2. Date of De Month	ath Day	Year	3. Time	of Death
	/Medic		MERLYN BRITTINGHAM SE								21,	2008	5:45	A M	
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			26378 East Pear 5. Social Security Number 6. S		ge (In yrs. la	of hirthdood	Crisfield birthday) If Under 1 Year If Under 24 Hrs. 8, Date of B						Somerset Sinth Day, Year) 9. Birthplace (State or Foreign Country)		
	Funeral Director		5. Social Security Number 6. S 577–60–7702	+ 67	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da July 4,	iy, Year) 10/13	V.	rginia	or Foreign	
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	Maryland -f show lied al		10a. State 10b. County		10c. City,	Town or Lo								10d. Inside	
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	Hem Hem	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent	?	5. 13.	If Yes, spec	cify Cuba	n, Mexicar	gin / (Spi 1, Puerto	ecify Yes or No Rican, etc.)	,- '	Black, Whit		
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Ma	# # # #		William Homer Wi		nion)						t - Cr				
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E O			1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Donation 5 ☐ Other (Special			e Episo	opal (l i	1/26	80\3	Puro	ly, Vir	ginia	
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Вох	th cer tendir or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Lîve birth			Ectopic pi	regnancy				2	3d. Date of de Month	livery Day	Year
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Records,	signe d be	d by	Valuela	Hert	Da	عام	5	10	nent	ace	nest 10	~	-	robably 4 [
cor	been been shou	ete	10.00	7			/		1		24a. Was	20	24b. Were a	utopsy finding	s available
Re	The law ate has page 2 s	Completed	11 D	0.	الدي	way					auto perfo		prior to death?	completion of	cause of
ta	icien: Th certificate ector, pag	ပိ	25. Was case eferred to dical	celin					26 Plane	of Deat	1 ☐ Yes	201No	1 🗆 Yes	s 2 □ No	
>		To B	examiner:	Hospital:	ent 2 E	R/Outpatier	nt 3 🗆 DC	Othe	200	irsing Ho	10		i □Other (Spe	ecify)	
10			27. Manner of eath	28a. Date of Inj (Month, Da	-	28b. Time o Injury		8c. Injury			28d Describe				
io	Attending r death. sctor: After by the fune	atio	1 Delivatural 5 Pending investigation	n	, , , , ,	qury	М		Yes 2 🗆	No					
Division of Vital	or Att	Certification:	3 Suicide 6 Could not be determined	289. Place of In	jury - At hor tc. (Specify)	me, farm, sti	eet, factor	y, office			28f. Location (City or To			ural Route Nu	ımber,
	Hospitel of the hours af Eunerel D	Ce													
	Hos 24 ho Fun Fun	edical		nysician: To the best miner: On the basis of and manners	of examinati										9(s)
	To the Hospitel or Attenswithin 24 hours after deatl To the Funerel Director: completely filled in by the	Mec	29b. Signature and title of gertifier	and maining 5	swal		290	c. License	number			29d. Date	e signed (Mon	th, Day, Year,)
	~ s ⊢ ō		> Vikille				1	130	538	160	2	/	3/-1	2-0	8
			10. Name and address of person who	completed cause of	death (Item	23a) (Type,	-		-)(~		, ,		
5	E3		John D. Whittake	er, M.D			treet	- F	Pocom	oke	City, M	ID 2	1851		<u>-</u>
4	Sta		31. Date filed (Month, Day, Year) JAN 22	2008	rar's Signati	ure	1								
	Registi	ar	JAN & &	2000	eu.	15	GIZDA!	ومسيخ							

			For State Registrar	State of Mary	/land / l		artment of H rtificate of L			giene Reg. No.2	g n2g o l.
			Decedent's Name (First, Middle, Last	·)					2. Date of De	ath	3. Time of Death
	Physicia /Medic		LAWRENCE TO						Month	Day Yes	8 4.10 AM
)	Examin	er	4a. Facility Name (If not institution, give		LACOLD	4.1	4b. City, Town, or			4c. County of D	GOMERY
				, —	n yrs. last bi		OLNEY,	If Under 24 Hrs.	8. Date of Bird		
	Funeral Director		071-12-0288	M 2□F	85 	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) 22, 1922	Birthplace <i>(State or Foreign Country)</i> Ch i na
	pur *	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10									
	sho sho	5			,,			ver Spring			1 ☐ Yes 2 ☒ No
	the N 28a-f notifie	Directo	Maryland Montgo 10e. Street and Number	mery			10f. Zip Code	ver spring		10g. Citizen of What	Country?
	with a or							20906		U.S.A	-
	eath	era	12800 Littleton St	12. Was Decedent Eve	r in U.S.	13.1	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No		merican Indian,
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ⊠ Yes 2 ☐ No					Rican, etc.)	Black, W	Vhite, etc.
3	urs a al', o Exam	ò	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWII		1 ☐ Yes 2 ☑ No	Specify:		Specify:	Asian Chinese
21215-0036	72 ho natur lical	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a	a. Dece	dent's Usual Occupa	ation during most of wor	kina	16b. Kind of Busine	ess/Industry
2	ithin le. lan "	ם	Elementary/Secondary (0-12)	College (1-4or 5+)		life. I	DO NOT use retired) -	9		
2	ed w ygier ner th	S	12		Re	estau	ırant Manage		- /5:	Hotel & Re	estaurant
n a	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)			, Maiden Surname)					
3	narke	ဥ		nknown	10	h Mailie	na Addrana (Ctrant	and Number or Ru		Unknown er, City or Town, Stat	to Zin Cada)
Maryland	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relationship (7)	,			•			ng, Maryland	
o O	1 and Healf em 2		Mary Tom - Daughter-1 20a. Method of Disposition				osition (Name of matory or other place		Date	20c. Location - City	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any ilury or other traumatic event, the Medical Examiner must be notifiled at once.		1 ⊠ Burial 2 ☐ Cremation 3 ☐	nemoval from State				!	L9/2008	Prontwood	Maruland
	artme artme ortani injury		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Savice Ucens		Fort I	COLUMN TO SERVICE	oln Cemetery 2. Name and Addres	random Wart to Bride	19/2006	Brentwood, 1	Maryland
Ba	Dep Imp any		Dones !	Ve a Voye	~	F	Hines-Rinald L1800 New Ha	li Funeral ampshire Av	Home, Inc enue, Sil	ver Spring,	Maryland 20904
	-		23a. Part 1. Enjer the disease, or comp shock, or heart failure. List only of	plications that caused the	e death. Do						Approximate Interval Between
	Physician	å Ti	Immediate Cause (Final disease or condition				PNEUMON				Onset and Death DAYS
1	/Medical		resulting in death)	a. Due to (or as a c			FINEOFION	0117			5/1/3
	Examiner	Ш	Convention list conditions	h							
	D .≓	iner	Sequentially list conditions, if any, leading to immediate cause. Error Unorthing Cause (Disease or injury	Due to (or as a c	onsequence	e of):					
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		- 6					
90,	oe execian a	<u> </u>	resulting in doddin Edec	Due to (or as a c	onsequence	e or):					
68760,	ficate be executed physician and is the burial-transit	edical		.d							
			IF FEMALE:	23c. If yes, outcome pf	pregnancy					23d. Date of	fdelivery
Box	atten for u	cian	in the past 12 months?	1 ☐ Live birth 2 [4 ☐ Pregnant at tin	Fetal deat		□Ectopic pregnancy □ Other (specify)	/		Month	Day Year
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	law requires that the death cert as been signed by the attending 2 should be detached for use a		Part II. Other significant conditions of	ontributing to death but r	not resulting	in the u	inderlying cause giv	en in Part I.	23e. Did	tobacco use contribu	te to the cause of death?
or Vital Records,	quires n sigr uld be	d by							1 🗆	Yes 2 No 3	☐ Probably 4 ☐ Unknown
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ita	an: tiffica tor, p	Be C	25. Was case referred to medical		-			26. Place of Dea			100 20110
>	lysici is cel direc	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/C	Outpatie	nt 3 DOA Oth	er: 4 Nursing H	lome 5□Res	idence 6 □Other (Specify)
0	ding Physician: The n. After this certificate ha funeral director, page	T:U	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y		. Time c	of 28c. Injur Wor	y at k?	28d. Describe	how injury occurred	
<u>S</u>	endir ath. or: Af	atio	2 ☐ Accident investigation					Yes 2 □ No			
Division	r Atte er de irecto	tific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc.		farm, st	reet, factory, office			(Street and Number o wn, State)	or Rural Route Number,
	ital ors aft ral oral ral oral bl	Certification:						<u> </u>			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical		ysician: To the best of i	xamination a						
	To the I within 2. To the I complet	Med	29b. Signature and title of certifier	and manner state	d		29c. Licens	e number	Т	29d. Date signed (A	Month. Dav. Year)
	¥ ¥ ¥ 8		10010					065661		1/16/2	
	3		20 Name and address of name of	completed source of de-	th (Itom 00-) /Tunn		(1,010	· · · · · · · · · · · · · · · · · · ·
			30. Name and address of person who		8101	P	RINCE Pr	nilip Driv	e Olne	4, MD 20	832
	Sta	ate	31. Date filed (Month (Mar))	2002 32. Registrar's			1	1		1'	
	Regist		V. 111 3. U. 2	A CONTRACTOR	es AS.	1	market				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1/14/2008 **Physician** Joseph John Tessitore 10:30am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 163 Friar Tuck Rd. Sherwood Forest Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 X M 2 □ F 154-32-0481 Director 1/13/1941 NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2XXNo Director MD Anne Arundel Sherwood Forest 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 163 Friar Tuck Rd. 21405 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must bonce. Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 257 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Property Manager Import/Export 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Tessitore Philameno Fabiano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 163 Friar Tuck Rd. Sherwood Forest, MD 21405 Marguerite Tessitore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/16/2008 4 □ Donation 5 □ Other (Specify) Metro Crematory Baltimore, MD 21. Signature of Functial Sery 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 fr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part1. Enter the disease, or comshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARRY TH MIA /Medical Due to (or as a consequence of): **Examiner** PULLTONARY OBSTRUCTIVE HRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 4☐Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown ONGESTIVE Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 잍 1 ☐ Yes 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA Yo the river... within 24 hours after death. To the Funeral Director: After this of the funeral director. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

Brian Wolf, M.D. 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

116 Defense Hwy Suite 400 Annapolis, MD 21401 32. Reginar's Signature JAN 1 7 2008

D 0061776

29d. Date signed (Month, Day, Year)

JANUAR!

15 Z008

29c. License number

Registrar

		For State Registrar	State	of Maryl		artment of F rtificate of		Mental H	ygiene Reg. No. (2008	02896	
		Decedent's Name (First, Middle	, Last)					2. Date of D	eath		3. Time of Death	
Physicia /Medic		Gertrude Louise	Turner					01/11	/2008	Year	3:00PM	
Examine		4a. Facility Name (If not institution		,		4b. City, Town, o	r Location of De			ounty of Death		
	,	Bowie Health Ca				Bowie	T #11-40411			nce Geo		
Funeral Director		5. Social Security Number 579–26–2097	6. Sex 1 ☐ M 2 ☐ ▼F	7. Age (In)	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Mi	in. (Month, E	Day, Year)	Cour	* *	
1 24	ŀ	Usual Residence of Decedent						06/24	/191/	Penns	sylvania	
ryland how	, [10a. State 10b. County			City, Town or Lo	cation			_	1	0d. Inside City Limits	
e Ma 3a-f s	cto	Maryland Prince	George'	s B	owie						1X Yes 2 □ No	
vith th	Dire	10e. Street and Number				10f. Zip Code	_		_	n of What Cour	ntry?	
eath v	eral	12110 Tawny Lane		cedent Ever i	nlis 13 1	2071 Was Decedent of F		(Specify Ves or N	U.S.	A . . Race - Americ	an Indian.	
DEJILITIOFE, INIGITYIBING Z I Z I 3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	/ Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed	Forces?		If Yes, specify Cub 1 □ Yes 2 ∑ No	an, Mexican, Pu	erto Rican, etc.)		Black, White,	etc.	
5-UU3G 72 hours af natural", or	ed by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent	Year or	Dates:	16a. Dece	dent's Usual Occur	pation			of Business/Inc		
L L L L L L L L L L L L L L L L L L L	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed	(1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of w d)	vorking			,	
AL.	Š	12			Homem	aker				wn Home		
Viano	Be	17. Father's Name (First, Middle, Edward Barton	Last)					lame (First, Middi		urname)		
yla	욘		in (Time Drint)		10h Mailin	an Address (Chast		ena Clar		C4-4- 7:-	. 0-1-1	
d 2 sl d 2 sl th an traur		19a. Informant's Name/Relationsh Donna M. King/d							nber, City or Town, State, Zip Code) ryland 20715			
s 1 an F Heal F Heal item 2	1	20a. Method of Disposition		20		sition (Name of matory or other pla		Date Pla		ation - City or To	own, State	
Pages ent o nt: If i		XX Burial 2 □Cremation 4 □Donation 5 □ Other (S)	3 ☐Removal from Decify)	L.	akemont Gardens	Memorial	1	/18/2008	David	convill	e, Maryland	
Dallimor permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service	icensee		Gardens 22	2. Name and Addre	ess of Facility	Robert E	. Evan	s Funer	al Home	
		1 Luc	25			6000 Ann						
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause or	caused the c	death. Do not ent	er the mode of dyi	ng, such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Death	
Physician	Ì	Immediate Cause (Final disease or condition resulting in death)	a.	Puln	mony	Embul	15				Onset and Death	
/Medical Examiner		resulting in death)	Due to	o (or as a con	sequence of):							
$\mathcal{E} = \mathcal{E}$	-	Sequentially list conditions, if any, leading to immediate	b	o (or as a con	sequence of):							
ansit	Examiner	Cause (Disease or injury										
cate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last	Due to	o (or as a con	sequence of):							
or ou,	dical		d									
OX O	Mec	IF FEMALE:	220 If you	utcome pf pre	ananay					d. Date of delive		
eath o attenct for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	birth 2 □ I gnant at time	Fetal death 3	Ectopic pregnanc	у		23	ery Day Year		
the d	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unk		ordeatr 3L							
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Pt	Part II. Other significant condition	en in Part I.	23e. Dio	e contribute to the cause of death?							
equire	ed b							1	Yes 2	No 3□ Prot	oably 4 □Unknown	
he law requires to has been signed as 2 should be or	Completed							24a. Wa	is an topsy	24b. Were auto	ppsy findings available mpletion of cause of	
The The page	٥								formed?	death? 1 ☐ Yes		
vital ician: T certifical ector, pi	Be (25. Was case referred to medical examiner?	Magnitaly					Death (Check only	one)			
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ding h. After funer	ig	1 Natural 5 Pending 2 Accident investig	(Mc	onth, Day Yea		Wo	rk? Yes 2 □ No	200. Describ	e now injury	occurred		
Attending r death. ector: Afte by the fune	Certification:	3 Suicide 6 Could r 4 Homicide determ	ot be 28e. Pla	ce of injury - /	At home, farm, str	eet, factory, office	-	28f. Location	(Street and	Number or Rum	al Route Number,	
ral Dir	Cert		10									
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical		Examiner: On the			h occurred at the to vestigation, in my						
To th within To th compl	Me	29b. Signature and title of certifier		\		29c. Licen		· · · · · · · · · · · · · · · · · · ·	29d. Date	signed (Month,	Day, Year)	
		1 Conn	Ý	ND		1)	JUS 37 4	5	Jo	2N 15	Th 2608	
		30. Name and address of person	who completed ca	use of death	(Item 23a) (Type,	Print)	Fux	lane	STE.	# >//	R 110	
Sta	te	31. Date filed (Month, Day, Year)	117W UF	Registrar's S	ignature	Galland beeks			-) 6	M.	BON'E D 20715	
Registra	ar	JAN 1	6 2008	Color	, J. A	peri						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23c per doc 9881 7-9-08 vt. State of Maryland 7 Department of Health and Mental Hygiene amend line 23a, a-b per phy aaco hlth dep state 01/28/08 dlw Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 12, 2008 Miriam Scott Utgoff Рм 5:40 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 2 Ridge Road Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 067-38-5341 Director 91 5, 1916 Washington D.C Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 Xes 2 No Directo Maryland Anne Arundel Annapolis 10e, Street and Number 10g. Citizen of What Country? 21401 2 Ridge Road United States Funeral 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items any Injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 TVNo If Yes, Give TX Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ATNo Specify: Specify: 3√√Widowed 4 □ Divorced δ White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas A. Scott Rebekah Wilmer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vadym<u>W. Utgoff / Son</u> 3616 51St. NW. Edmonton, Alberta Canada T6L1C6 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/29/2008 Arlington Nat'l Cem. Arlington, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home, Ind. Miche 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Liver Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Lymphoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying — Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Renal Failure Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year 5 Other (specify) been signed by the a should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 1 Yes 24 No or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 → Mo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 [CertifyIng PhysIclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Robert 6 recepted aso 026373 1/14/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert M. Greenfield Id Rl oll Sdanois 31. Date filed (Month, Day, Year) 32. egistrar's Signature State JAN 1 7 2008 Registrar

Registra DHMH 17 Rev 1/2001

State

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

the Medical

within 72 hours after death

oe filed wn.

Ne Hygiene.

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permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumatic event, the once.

Baltimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

physician and s the burial-transit as attending p peen has certificate this

The law requires that the death certificate be executed

Records, P.O. Box 68760

Division or Vital

Examine Physician/Medical Completed Be P After 1 Certification: Hospital or Attending within 24 hours after uccur.

To the Funeral Director: A death. Medical

29a. Certifier

29b. Signature and little of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria Tayag 1500 Forest Glen Road Day, Year) N 18 State Registrar DHMH 17 Rev 1/2001

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2√☐ No 9 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2**X** No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**⋉** No 1 ☐ Yes 1 🙀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D63579

29d. Date signed (Month, Day, Year)

01/16/08

Silver, Spring, Md

and manner stated

ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. within 24 hours at To the Funeral C completely filled i

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State

Registrar

YHTOMIT LOW.

29b. Signature and title of certifig

29c. License number

D24034

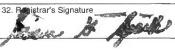
29d. Date signed (Month, Day, Year)

TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601 OSLER DRIVE

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:30AM CBRUANTY Hraabria 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMPRITAN HOSPITAL BALTIMORE. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 233-28-2618 1**X** M 2□ F Bluefield, WY Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County Examiner must be notifled at 1 ☐ Yes 2 No Baltimore Director Daltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 Funeral 12 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maideh Surname) Department of Heaith and Mental Hygin Important: If item 27 is marked other 17. Father's Name (First, Middle, Last) Be ပ ner Jaknown roger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) , Washington 1420 N Street Hrgabright Son 20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathodral Cenvery 20a. Method of Disposition 1 ■ Bunal 2 ☐ Cremation 20c. Location - City or Town, State 4 Donation 5 Dother (Specify) Baltimore 21. Signature of Funeral Service Licensee BALTI MORE, MO 21234 Evans Funcial Chap 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEP515 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No patient 2 ER/Outpatient 3 DOA 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 ATTONDING 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified DOO 60039 2008 MAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. 600 D TOW HOSPITAL

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

32.

nistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 ten 1 per doc 98/6 2-5-08 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Carole 3. Time of Death 2. Date of Death Ann Bayne Day **Physician** 200 Year A M 29 01 /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Pay, Apr. 9, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Maryland 1 □ M 2 T F Months Hours Min 1941 66 214-40-2168 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified the once. 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits MD Baltimore 1 □Yes 2 No Director Lansdowne 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4202 Hollins Ferry Road 21227 by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Landscape Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Schech <u>Pauline Berry</u> 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Bayne - Son 7720 Vena Court, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Arundel Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 2-1-2008 4 □ Denation 5 □ Other (Specify) Odenton, MD Crematory 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funerat Service Licens 2719 Hammonds Fry Rd., lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that cause he shock, or heart failure. List only one cause on each line e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hypothy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No Ostroporosi Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient Certification: To 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 26656 01 29/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DREE E. CALDERON, M.D - 4000 DANAPOUS RJ, BOLTIMOU, MD 31. Date filed (Month, Day, Year) 32. Rettar's Signature State Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MATTIE BENNETT Day Year FEBRUARY 3 07:36AM 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) January 15,1918 Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Months Days Hours 231-16-2277 Virginia 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Dundalk 1 ☐ Yes 2 ☐ Xio 10f. Zip Code 10g. Citizen of What Country? 21222 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ZXX 100

If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No Specify. White Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) Vera Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Husband 8136 Cornwall Road, Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February Bayview Crematory Baltimore City, MD. 4, 2008 Connelly Funeral Home of Dundalk, P.A. nct 7110 Sollers Point Road, Dundalk, MD. Approximate Interval Between Onset and Death HYPOVOLEMIA DAYS Due to (or as a consequence of): DECREASED ORAL INTAKE AND ANOREXIA MONTHS Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death Month 5 Other (specify) Day Year 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No 26. Place of Death (Check only one) 1 Inpatient Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Yes 2 No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

and the burial-tra Division or Vital Records, P.O. Box 68760. attending physician Hospital or Attending Physician; Director: n 24 hou. •he Funeral D within 24

Physician

/Medical

Examiner

Funeral

Director Usual Residence of Decedent 10a State 28a-f show ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at Director Maryland 10e. Street and Number 8136 Cornwall Road Funeral 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed filed withir Hygiene. Elementary/Secondary (0-12) 8 years 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental I is marked William Foritz 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2. Department of Health a Important: if Item 27 is any Injury or other trace Dick Lance Bennett 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Fundtal Service Licenses 23a. Part1. Enter the disease, of complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be 1 Yes 2 No 2 27. Manner of Death 1 Natural Certification: 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifie 20064724 February 3,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE BALTIMORE MD 21224 SPRAGG MD DAVID 4940 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2008 Registrar DHMH 17 Rev 1/2001 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Of Ivial Registrar		ertificate of		Reg	2000	02905
۳	Dhyoisi	a n	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
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	Examir	er	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Dea	
		7	Gilchrist Center		Towson	I 15 1 - 1 - 0 4 1 1 - 1		Baltimo	
Ľ	Funeral		1 M 2 M F	(In yrs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo	ear) C	thplace (State or Foreign ountry)
	Director		218-14-5225 12 12 12 13 14 15 15 15 15 15 15 15	•			July 30,	1923	Minnesota
	yland now at		10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
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	th the or 28 e not)ire	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	ountry?
	23a ust b	Funeral Director	210 Charmuth Road		210	193		USA	
	er deg	nue	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S.	Was Decedent of H If Yes, specify Cub	ispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
36	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	1 ☐ Yes 2 No	Specify:		Specify:	White
21215-0036	hour Itural	ed k	15. Decedent's Education	16a. Dec	cedent's Usual Occup	ation	16	b. Kind of Business	
15	nin 72 n "ne Medic	Completed	(Specify only highest grade completed)	(Gir	ve kind of work done e. DO NOT use retired	during most of working	ng	o. Tana or baginess	, madely
212	d with giene or tha	mo	Elementary/Secondary (0-12) College (1-4or 5+)		memaker			Own Hom	e
b	e filed al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Mai		
<u>Ja</u>	uld b Ment arked atic e	To E	Albert Martin Johnson			Alice	B. Luns	strom	
Maryland	2 sho and is ma		19a. Informant's Name/Relationship (Type. Print)	19b. Ma	ailing Address (Street	and Number or Rura	l Route Number, C	City or Town, State,	Zip Code)
	and lealth m 27 her tr		David Burrows (son)	17	20 Fleet S		ltimore,	MD 212	
0	ges 1 If of F If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, ci	position (Name of rematory or other place	^{≫)} ¦02/05	ate 2008 200	c. Location - City or	
Ë	t. Pa rtmen rtant:				Valley Mem	ı. Gardens		Timonium	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signal of Funeral Service Licensee		22. Name and Addre		ck lowsor son, Mary		Home, Inc. 204
	5000		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	ne death. Do not ε	enter the mode of dyir	ıg, such as cardiac o	r respiratory arrest	,	Approximate Interval Between
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В	Examiner		Sequentially list conditions b.						
4 - 4	pi, it	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):					
	and A	Examiner	that initiated events	consequence of):					
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			IF FEMALE: 23c. If yes, outcome pf					23d. Date of de	livery
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ğ	w requires been signe should be						1 ☐ Yes	2 No 3 P	robably 4 Unknown
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Vita	sician: The law s certificate has t irector, page 2 s	Be (25. Was case referred to medical examiner?			26. Place of Death			
7	Attending Physician: The r death. ector: After this certificate haby the funeral director, page	P	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient			4 LI Nursing Hor	ne 5 🗆 Residenc	e 6 Other (Spe	ecity) haspie
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<u>s</u>	ten eath tor; the	cati	2 Accident investigation 3 Suicide 6 Could not be 380 Place of injury	. At home form	M 1 □ street, factory, office	Yes 2 □ No	105	4	
Division or	I or Attendatter death	Certification:	4 Homicide determined building, etc.	(Specify)	street, factory, office	2	City or Town, S	et and Number or H State)	ural Route Number,
	Hospital 24 hours 8 Funeral tely filled		29a. Certifier Certifying Physician: To the best of	my knowledge, de	ath occurred at the tir	ne, date and place.	and due to the caus	se(s) and manner a	s stated.
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	(Check only one) 2 Medical Examiner: On the basis of e and manner state	xamination and/or ed.	investigation, in my o	pinion, death occurr	ed at the time, date	and place, and du	e to the cause(s)
	To the within 2 To the comple	ž	29b. Signature and title of certifier		29c. Licens	e number	29d.	Date signed (Mon	th, Day, Year)
	٨		> years on		105	8305	FC	Grony of	7008
			30. Name and address of person who completed cause of dea	th (Item 23a) (Type	e, Print)	1	~	/	
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	Sta Registr	_	31. Date filed (Month, Day, Year) SER 0.5 2008 32. Registrar's	s Signature	e, Print)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year William J. Blueford 10:45AM 28 TANARY 2008 /Medical Town, or Location of Death 4c. County of Death Examiner timo If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F 91 Yrs. 218-01-1171 Director March 7, 1916 Marvland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits r 28a-f show notified at show 1 ☐ Yes 2 No Director Marvland Baltimore Catonsville 10e. Street and Number 10g, Citizen of What Country? 10f Zin Code 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 21228 United States 513 Herberts Run death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Cummins Radiator Co. 7 years n/a President 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be (and Mental h Pages 1 and 2 should be William J. Blueford, Sr. Johanna Wolfram 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health a 6451 N. Charles St. Unit 331 Baltimore, MD 21214 Joan B. Blueford (wife) permit. Pages 1 and Department of Health Important; If item 27 any injury or other tr. Once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 2-1-2008 Baltimore, Maryland 22. Name and Address of Facility of Funeral/Service Licensee McCully-Polyniak Funeral Home, 130 E. Fort Ave. Baltimore, MD J. Wayne Osterling se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, start only one cause on each line. 23a. Part1. Enter the disea Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARC TOON /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) s been signed by the sign should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an funeral director, page 2 2 No 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2. ER/Outpatient 3 □ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1, Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Hospital 29a. Certifier l 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier D0051865

State Registrar CNV3

BATTIMERE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day,

CURTIS

32 Registrar's Signature

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rederick Bartter		State of Maryland / Department of Health and Mental Hy	/giene	A.m. Co.	
		Registrar Certificate of Death		g. No.	
Physicia			Date of Death Month		3. Time of Death
″ al Exami	ner	riederic crossy Bartter, br.	Month February 1.		1508 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
		2821 St. Paul Street, Apt. 4 Baltimore		N/A	
Funeral		Manha I Dana I Hausa I Man	_	(MM/DD/YYYY) 9. Birt Foreig	
Director		577-62-2228 XXM 2 F 59 Yrs. Months Days Hours Min.	July 1		stachusetts
	ļ	Usual Residence of Decedent			
v any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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1arylı 28a-f	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	try?
215-0036 be filed within 72 hours after death with the Maryland nual Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once.	흠	2821 St. Paul Street 3rd Floor #4 21218		USA	
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5-0036 led within 72 hours after Hygiene. I other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, M	laiden Surname)	
215 oe filo ntal H ked	Be (Dr. Frederic C. Bartter, Sr. Jane I	L. Lilla	ırd	
D 21215-003 should be filed within and Mental Hygiene. 7 is marked other th. natic event, the Medi	흔	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R	Rural Route Numi	ber, City or Town, State	Zip Code)
		Jane Bartter Mother 227 Primrose Place,	San Ant	onio, Texas	78209
	ı	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I ar Department of Hec Important: If ite		Metro Crematory 2/4	4/2008	Catonsvill	e, MD
Itin nit. P artme ortar	H	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee / 22. Name and Address of Facility			
Baltimo permit. Page: Department o Important: I		dynn B. Henss Burgee-Henss-Seitz 3631 Falls Road, E	Funera	1 Home, Inc	21211
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	r respiratory arre	est, shock, or heart	Approximate Interval
Medical	Į	failure. List only one cause on each line.			Between Onset and Death
_xaminer		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			
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Sox 687 leath certific e attending p	cia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	,		,
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८ € के		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	i	bacco use contribute to	
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Division To the Hospital or At within 24 hours after to the Funeral Direct completely filled in by	ig	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
To t with Com	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number	,	29d. Date signed (Mo.	
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/		O.C.M.E.		February 2, 2008	
37		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	1		
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Registrar

State

Kaven

Battimore, MD 21239

30. Name, and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

31. Date filed (Month, Day,

MD

5001

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day A M Ear1 L. 8:20 Butz 2, 2008 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3906 Dresden Street Kensington Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Director 98 311-07-8191 July 3, 1909 Indiana Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County show 10d. Inside City Limits a or 28a-f show be notified at Director 1 Y Yes 2 No Indiana Tippecanoe W. Lafayette 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a 2741 N. Salisbury Street Examiner must 47906 Funeral United States hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🛛 No Specify þ Specify: White 3 Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumout. 5+University Dean Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Lee Butz ပ Ada Lower 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William P. Butz/Son 3906 Dresden Street, Kensington, Maryland 20b. Place of Disposition (Name of cometery, crematory or other pla Tippecanoe Memory Gardens 20a. Method of Disposition 20c. Location - City or Town, State February 1 X Burial 2 ☐ Cremation 3 □Removal from State 4 Donation 5 Dother (Specify) 2008 W. Lafayette, Indiana 21. Signature of Funeral Service License Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc. M01173 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Arrest /Medical Due to (or as a consequence of) **Examiner** Arteriosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examin be executed burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) P.0. the detached 9□Unknowr 9 Unknown 2 signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performe 2X No Division or Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Residence ပ 1 ☐ Yes 2X No 1 | Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? Certification: ospital or Attending hours after death. Injury 1 XX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident nin 24 hours after death the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 0 D26478 February 2, 2008 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Fahey, M.D. UofMD Health Center Campus Drive, College Park, MD 20742 Stephen R. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 05 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** FEBRUARY 2, SHARON ANN BEALL 2008 8:10 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL AIR Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 28 □ F Maryland June 5, 1946 219-60-7369 61 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.
ther than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☐ No Funeral Director Harford Marvland | Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be I USA 21085 2524 Mountain Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 Is marked other ti any Injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Icie Myrtle Boggs Cecil Hubert Beall ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>2524 Mountain Road, Joppa, Maryland 21085</u> Carole B. Sniegowski / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park 2-5-08 Baltimore, Maryland 21. Sonature of Fundral Service Lice See 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Bilater Physician neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Cualto (or as a consequence of) Examiner it any, leading to minious cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iding physician and ise as the burial-tran Due to (or as a consequence of): certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) ģ 23e. Did tobacco use contribute to the cause of death? signed it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 → 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☐ No 24a. Was an autopsy this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes Inpatient 2 ER/Outpatient 3 DOA မှ 28c. Injury at Work? funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation Injury Hospital or Attending Natural 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Maryland 21215-0036

Baltimore,

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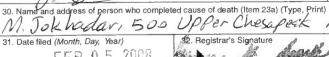
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Division or Vital

M. Jok hadari 31. Date filed (Month, Day, Year) State FEB 05 Registrar

29b. Signature and title of certifier

2008



29c. License number

060768

29d. Date signed (Month, Day, Year)

Drive, Bel Air, MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Carla Elaine Barro	1	Dunn - For State Registrar	St	ate o	f Maryla	and / [•	rtment o	f Health a f Death	nd N	/lental l	Hygie		g . N o.	20	08	0291
Physician Medical Examine	1	1. Decedent's Nam			RRON	-DUN	IN						te of Death onth nuary 26		Year 8	;	3. Time of Death 0931 hrs
		4a. Facility Name (i 620 Coachr		n, give s	treet and nu	imber)			4b. City, Town, Parkton	or Loca	ation of Dea			4c.	County of C altimore		ity
Funeral Director		5. Social Security N		6. Sex	1 2 X F		n yrs. la	st birthday)		_	f Under 24H Hours M) 8 / 1 (F	9. Birth oreign Cour	
any	-	Usual Residence o 10a. State	f Decedent 10b. County			10	c. City,	Town or Loca	ion							1	10d. Inside City Limits
-f show	5	MD	BALT	IMC	RE			PARK	TON				140	An Citize	en of What		1 Yes 2 No
the Mary is or 28s	2	10e. Street and Nu 620 COA		s w	AY					L12	0		10	-	SA	Count	iy:
be filed within 72 hours after death with the Maryland mal Hygiene. Treed other than "natural", or items 23a or 28a-f show any ent, the Medical Examiner must be notified at once.	runeral	11. Marital Status 1 Never Marri		arried	12. Was Dec Armed F 1 Yes	orces?	_	S. 13. Wa	as Decedent of I	an, Me	exican, Puer	Specify ' rto Rican	Yes or No- , etc.)		White, 6		an Indian, Black,
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5-0036 led within 72 Hygiene. other than 'the Medical	Completed	17. Father's Name		l act)	5+			VICE	PRES.		NEFI'					EAI	LIFE-H.
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Baltimo permit. Page Department o Important: injury or oth	١	21. Signature of Fu	neral Service	License				116	Name and Addre	DRK	RD I	MONI	KTON	, MD	. 21	111	
Physician /Medical		23a. Part I. Enter the failure. List on Immediate Cause (ly one cause	on each	iline.			Do not enter thromboem		ng, suc	h as cardia	c or resp	iratory arre	est, shoo	ck, or hear t	Ę.	Approximate Interval Between Onset and Death
caminer		or condition resulti	ng in death)	Du	e to (or as	consequ	ence of								_		
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Records, P.O. Box 68760 The law requires that the death certificate cate has been signed by the attending physpage 2 should be detached for use as the by the control of the Deviction of the control of the Deviction of the control of the Deviction of the control of the Deviction of the Control of the Deviction of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Co	Σ١	IF FEMALE: 3b. Was decedent past 12 months 1 Yes 2	\$?		23c. If yes, 1 Live I 4 Pregi	oirth nant at tim	_	2 Fe	etal death ther (Specify)	3 <u> </u>	Ectopic preç	gnancy			. Date of de Month		ay Year
P.O. Es that the gened by the edetached	5	Part II. Other signi	ficant condit	ions c	ontributing t	o death b	ut not re	esulting in the	underlying caus	se giver	n in Part I.		23e. Did to				he cause of death?
n of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by tuneral director, page 2 should be detach	Completed							-				-	24a. Was a autop: perfor	sy med?	pri de:		opsy findings available ompletion of cause of
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	₽┞	1 2	2 No		28a. Date	Inpatient of Injury n, Day,Year		ER/Outpatien 28b. Time of	Injury 28c. li	njury a	t Work?	sing Hor 28d.			ry occurred		Scene
Division Within 24 hours after death. To the Funeral Directors. To the Funeral Directors. completely filled in by the fi	Ceruncation:	2 Accident 3 Suicide 4 Homicide	Inve	stigation d not be rmined	28e. Plac		y - At ho	ome, farm, stre	et, factory, offic				Location (S or Town, S		nd Number	or Rur	al Route Number, City
To the Hospi within 24 hou To the Function completely file	<u>.</u>	29a. Certifier	Certifying P Medical Exa	miner: C	n: To the be on the basis	of examir	nowledg	ge, death occu nd/or investiga	rred at the time, ation, in my opin	, date a ion, de	and place, a eath occurre	and due t	o the caus time, date a	e(s) and and plac	d manner a	s state e to the	d. cause(s)
F M F S	Me	29b. Signature and	title of certific		- Pa	003	س ب	~	29c. Lice O.(ense nu C.M.E					Date signed Jary 27,		th, Day,Year)
87		30. Name and addr Patricia Aro					,	^{23a)} Examiner	111 Penn	Stree	et, Baltim	ore, M	D 2120	1			
Stat Registra	~	31. Date filed (Mon		5 20	08 ^{32. R}	gistrar's	Signatu	rg A	sell?								
DHMH 17 Rev 1/200			LUV	DOME		77.75		ORIGINA	\L								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10g, 17 per inf (876, 2-1/4-08 yt State of Marylang) Department of Figath and Mental Hygiene State Registrar Amend #30, per DVR, g876, 2/5/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician FEBRUARY 2008 2:45P M BARG ITA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **BETHESDA** MONTGOMERY SUBURBAN HOSPITAL 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month. Day 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min 06/20/1922 1 □ M 2X F 85 214-71-3064 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 TYes 2 No GAITHERSBURG Director MONTGOMERY MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20877 101 ODENDHAL AVENUE, #405 Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MEDICINE MEDICAL DOCTOR the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ABRAM** BARG ROSA DIMANT MOSHE ဂ and l 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once. 6522 WINNEPEG ROAD, BETHESDA, MD 20817 ALEXANDER BARG / NEPHEW 20b. Place of Disposition (Name of JUDEAN PROPERTY OF THE MORTIAL Place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Bunal 2 ☐ Cremation 3 ☐ Removal from State 02/04/2008 OLNEY, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner ACUTE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner physician and the burial-tran Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 ☐ Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown CHOLECYSTITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident al or Attend s after death Il Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated 29c. License number 0 66066 29d. Date signed (Month, Day, Year) 29b. Signature and title of Pertifier 30. Name and address of person who completed cause of dath (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 05

Andrew Leung-Doon Wong, MD Suburban Hospital Bethesda, MD

32 Registrar's Signature

Carl Ball

18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3317 Elm Avenue Baltimore, Maryland 21211 20c. Location - City or Town, State Baltimore, Maryland ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State FEB 05 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

5:30 AM

9. Birthplace (State or Foreign Country) West Virginia

10d. Inside City Limits

1X Yes 2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death [™]83 Month ď **Physician** Welford Corbin 11:00a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Baltimore 1411 Clif 5. Social Security Number Cliftview Ave If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
11 1 4 Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) **Funeral** Days 48 Director 214-50-4139 59 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 10a State 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Des 2 No Directo Baltimore NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with U.S.A 21213 <u>1411 Cliftview</u> Ave. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ X o If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Schools BS Degree Teacher 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) Be Smith Neonta Corbin Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Girl LaMarrien Lincoln-1411 Cliftview Ave.Baltimore,MD21213 Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Conation 5 ☐ Other (Specify) Mt.Zion Cemetery 2/9/08 Lansdown, MD ature of Funeral Service Licensee 22. Name and Address of Facility 21. Sig March F/H East 1101 E.North Ave.Baltimore, MD21202 arty Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hook, or heart failure. List only one cause on each line. le Cause (Final or condition in death) **Physician** /Medical Due to (of as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Desidence 6 □Other (Specify) 1 🗆 Yes 3□ DOA 2 ER/Outpatient Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) 2/5/08 225Greene St Bathmon, MD 31. Date filed (Month, Day, Year) State

Registrar

FEB 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7, 8 per fh 9876 2-5-08 vt. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 10a-c, 10e-f per FH G884rtilicate 08 DEath 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 205 **Physician** Kung Ping Chen Februar 8005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3 QLTIMORE ROSEORCI C.

If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. FRANKLIN 5. Social Security Number Square Hospital Center 8. Date of Birth **1955**(Month, Day, Year)
May 06, 1956 9. Birthplace (State or Foreign Country)
Talpel, Taiwan e (In yrs. last birthday) **Funeral** Months 067-64-3578 Director Usual Residence of Decedent 10b. County Monmouth 10c. City, Town or Location Manalapan 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State NJ 1 ☐ Yes 24 No Baltimore County Director Cockeysville 10e. Street and Number 25 Winfield Drive 07726 10f. Zip Code 10g. Citizen of What Country? 21030 United States 17 Laurelford Cour Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 **₫**Ño Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Taiwanese þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Computer Business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Yeh Ping Hong Chen Frank Hsin Huei Chen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cockeysville, Maryland 21030 17 Laurelford Court Dr. Lily Lin (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Feb.05, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem.Gar. 2008 Timonium, Maryland 4□Donation 5 Other (Specify)Entombment Peaceful Alternatives Funeral&Cremation Ctr.,P.A 2325 York Road Timonium,Maryland 21093 21. Signature of Funeral Service License h. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failing. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death) **Physician** a NONsmall cell cancer of Lung 5 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner A Pil The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physiclan for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has autopsy performed 2 No this certificate Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ပ After th funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation 1 Natural To the Hospital or within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature a 29d. Date signed (Month, Day, Year) 30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print) (C) FRANK DR Balto md 9000 LIN Square 21237 merchant 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 05 2008 Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Physician Kathryn B. Cole /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Timonium Baltimore 5. Social Security Numbe 212–36–4180 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 2/8/1938 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 💥 F 69 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 28a-f show Department of Health and Mental Hygiene. Improved the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the sta Maryland Baltimore Towson Director 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code death with 722 Milldam Road 21286 of America Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/2 No 2 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) self employed professional artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Robert Bonsall Kathryn Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathryn C. Jackson/ daughter 722 Milldam Road Towson, Maryland 21286 FEBRUARY Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Pages ' Evans Funetary or other place) February 1 ☐ Burial 2XX remation 3 ☐ Removal from State Chapel- Bel Air 4 ☐ Donation 5 Other (Specify) 2008 Forest Hill, Maryland Peaceful Alternatives Funeral & Cremation Ctr 2325 York Road Timonium, Maryland 21093 21. Signature of Fugeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Examiner

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

burial-trar attending properties for use as ed by the a detached f peen page 2 s

P.O. Box 68760

Records,

COLE

KATHRYN Division or Vital certificate has

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director,

Certification:

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Medical

29b. Signature

DR. EDDIE NAKHUDA

State Registrar

torrestate Occasion (Ether)		1 3 2000	Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a	<i>'</i>	
resulting in death)	a. Due to (or as a consequence of): 2 4 2 6 2 1 2 4 2 5 7 7 5	500	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):		74
cause. Enter Underlying Cause (Disease or injury that initiated events			
that initiated events resulting in death) Last	Due to (or as a consequence of):		
	d		
in the past 12 months?	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
1 ☐ Yes 2 X No	9□Unknown	1	
9 Unknown		23e Did tobacco	use contribute to the cause of death?
9 Unknown	9□Unknown Intributing to death but not resulting in the underlying cause given in Part I.	7.7.	use contribute to the cause of death?
9 Unknown		7.7.	use contribute to the cause of death? □ No 3 □ Probably 4 X Unknown
9 Unknown		1 ☐ Yes 2 24a. Was an autopsy performed?	No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
9 □ Unknown Part II. Other significant conditions co	intributing to death but not resulting in the underlying cause given in Part I.	1 ☐ Yes 2 24a. Was an autopsy performed? 1 ☐ Yes 2 🛣 No	No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
9 ☐ Unknown Part II. Other significant conditions co	intributing to death but not resulting in the underlying cause given in Part I.	1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 No. (Check only one)	No 3 □ Probably 4 ▼ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
9 ☐ Unknown Part II. Other significant conditions co	intributing to death but not resulting in the underlying cause given in Part I.	1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 No. (Check only one)	No 3 □ Probably 4 ▼ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
9 ☐ Unknown Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I. 26. Place of Death Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom 28a. Date of Injury 28b. Time of 28c. Injury at 28b.	1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 No. (Check only one)	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 X Other (Specify) HOSPICE
9 □ Unknown Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I. 26. Place of Death Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	1 ☐ Yes 2 24a. Was an autopsy performed? 1 ☐ Yes 2 ▼ No. (Check only one)	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 X Other (Specify) HOSPICE

TIMONIUM, MD 21093

29c. License number

Year

Black, White, etc.

Specify: White

29d. Date signed (Month, Day, Year)

2008

10:05 A.M

9. Birthplace *(State or Foreign Country)* Balt., Maryland

10d. Inside City Limits

Approximate

1 ☐ Yes 2 No

DHMH 17 Rev 1/2001

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Phruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner are If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days 1 1 4 M 2 □ F 79 243-36-0658 Usual Residence of Decedent Director 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 Yes 2 Ne Funeral Director 10g. Citizen of What Country? 10e Street and Number U.S.A. 21061 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Medical Department of health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meonee. Elementary/Secondary (0-12) College (1-4or 5+) river 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ledrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a_Informant's Name/Relationship (Type. Print) Burnie, led. 21061 Cash Glen 500 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenmount Genatury Feb 4 ☐ Donation 5 ☐ Other (Specify) 2008 28. Name and Address of Facility
1701 Mc Culluk 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYUCARDIAL INFARCTION **Physician** MINUTES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 1 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0051865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SI MONES MARLES CURTS 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 30, 12.29 p 2008 Colburn, January Stephen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Anne Arundel

9. Birthplace (State or Foreign Country) Annapolis ler 1 Year | If Under 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Sex 1X M 2 ☐ F **Funeral** Days Hours Min. Months 87 Dec. 26,1920 Director Maryland 214-18**-**7801 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show idical Examlner must be notifled at 1 ☐ Yes 2 ☐ No Directo Maryland | Anne Arundel Severna Park 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 316 North Drive 21146 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Saltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced White Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) Wireman <u>Westinghouse</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Colburn Barbara Alt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 North Drive Severna Park, Maryland Z1140 Marie D. Colburn (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 02/04/08 Glen Burnie, Maryland 32. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nyocava 1d **Physician** nows /Medical Due to (or as a consequence of): **Examiner** ongest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed brondy Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 | Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performe the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Tol 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Natural 2 Accident Injury To the Funeral Director: Aft

To the Funeral Director: Aft 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

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State Registrar

bleev 31. Date filed (Month, Day, Year) 2008 FEB 05

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 8 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician EUGENE** COLLINS WARREN 30 200% /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Glen Burnie Baltimore-Washington Medical Center Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 2.1932 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1MM 2□F 75 Director 414-44-2186 Tennessee Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County Glen Burnie 1 □Yes 2 No Anne Arundel Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 43 Chester Circle 21060 by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) W.R. Grace & Company Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Collins 2 W. Collins Nancy John 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43 Chester Circle, Glen Burnie, Maryland 21060 Joan Collins (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 01 - 31 - 08Baltimore, Maryland 21. Signature of Furnal Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. Maryland 21122 3204 Mountain Road, Pasadena, fant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** n/monan /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Year 5 Other (specify) the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 🗌 Yes 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Yes 2 No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintained as success.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) erson who completed cause of death (Item 23a) (Type, Print) pape, alen burne 30. Name and addre Gullen State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January Margaret Anne Cimino /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Timonium Stella Maris If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 05/07/1951 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** Year) Months Days 1 M 2 X F 212-58-8096 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County nen cr is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at N/A Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21206 3825 Bayonne Avenue Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2008 11. Marital Status 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Smith John McClaskev フィとゴゴム ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3825 Bayonne Avenue Baltimore, Maryland 21206 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other trau John E. Cimino, Jr. – Husband Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 02/05/2008 Parkville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Sofvice Licenses 22. Name and Address of Facility 5305 Harford Road Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Take to Jorge a consumisation offi use as the burial-transi and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) detached been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MARGARET On Division or Vital Records, Completed by 1 🗌 Yes 2 No 3 Probably 24a. Was an After this certificate has funeral director, page 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Sther (Specify) 2 No 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA P 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation al or Attendl s after death. Il Director: A 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 43725

State Registrar

31. Date filed (Month, Day,

Name and address of person who completed cause of death Item 23a) (Type, Print)

LR, TAR, PMAN, 000 C 23,00 RULANCY VOLLY RO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 X Yes 2 □ No

5:40 PM

2008

Maryland

White

Baltimore

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

4 Unknown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician WILLIAM HENRY CROMWELL SR. FEBRUARY 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Harford Be1 If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 □ F Director 213**-**28-2705 11, 1930 | Maryland Mar Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1647 Schucks Road 21015 Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌂 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) oe filed w₁. •al Hygiene. •er than "r Elementary/Secondary (0-12) College (1-4or 5+) Freight Company Truck Driver permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumation. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel John Albert Harris Sr. (UNK) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alma Cromwell / Wife 1647 Schucks Road, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) John Wesley LMC Cem 2-7-08 A 22. Name and Address of Facility McComas Funeral Home, P.A. Abingdon, Maryland 21. Signature of Funeral Service Licenses rula a 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myscardial Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Partyll. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 Tes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 27. Manner of Death

omma funeral e Hospital or Attending Pi 24 hours after death. e Funeral Director: After ti within 24 hours after death

To the Funeral Director:
completely filled in by the

Certification: To

28a. Date of Injury (Month, Day Year) 5 Pending investigation 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Viare un 29c. License number

Upper Chesapeake

29d. Date signed (Month, Day, Year)

30. Name and address of person with ted cause of death (Item 23a) (Type, Print)

Zamora, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) 2008 FEB 0.5

500

State Registrar

Medical

08-00917 Kerry Davis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

erry Davis	1.	For State Of Maryland / Departing	ate of Death		Reg	. No. 2 1	108 0292
Physicia		edistrar . Decedent's Name (First, Middle,Last)			. Date of Death Month	Day Year	3. Time of Death 0610 hrs
edical Examin	er	Kerry Davis	4b. City, Town, or I		February 2,	4c. County of Dea	
	4	a. Facility Name (if not institution, give street and number) 4112 Falls Road	Baltimore	LOCATION OF DOGS.		N/A	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birth			8. Date of Birth	(MM/DD/YYYY) 9. E Fore	Birthplace (State or eign
Director		215-58-1990 1 _X M 2 _D F 55	Yrs. Months Days	Hours Min.	JAN 13	1953	Country) MD
		Journal Residence of Decedent 10c, City, Town	or Location				10d. Inside City Limits
ow any		Oa. State 10b. County 10c. City, Town MD N/A Balti					1 X Yes 2 No
ryland	Director	Oe. Street and Number	10f. Zip Code		10	g. Citizen of What Co	ountry?
ith the Ma		4112 Falls Road	21211			USA_	nerican Indian, Black,
h with		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto F	ecify Yes or No- Rican, etc.)	White, etc	
or deat		1 Yes 2 X No Widowed 4 X Divorced If Yes, Give Year	1 Yes 2X No	specify:		Specify: W	nite
urs aft itural"	d b	Tor Dates:	Decedent's Usual Occupation during most of working life	tion (Give kind of w	ork done ed)	16b. Kind of Busines	ss/Industry
6 172 ho an "na	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	eneral Contra			Construct	tion
5-0036 iled within 7 Hygiene. I other than the Medica	E -	12 Ge	HICIAI GOILLE	18.Mother's Name	(First, Middle, N		
21215-00; uld be filed with Mental Hygiene marked other t	a B	Francis E. Davis		Clara	Binji	the City of Tourn St	tate Zin Code)
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-fahrante event, the Medical Examiner must be notified at once	2		314 Wildwood				
a alt m		20a. Method of Disposition 20b. Place	of Disposition (Name of ce		Date	20c. Location - City	y or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		1 Burial 2 X Cremation 3 Removal from State	Crematory,	Inc. 2/4	+/2008	Baltimor	e, MD
Baltimo permit. Page Department o Important: injury or oth		4 Donation 5 Other Specify: President Service Screen President H. Williams	22 Name and Address Cremation 299 Fred	is of Society	of Mar	yland, In	c. 21 220
	Ц	23a. Part I. Enter the disease, or complications that caused the death. Do r	299 Fred 6	, such as cardiac o	r respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
Physician Medical		failure. List only one cause on each line.					Death
aminer		Immediate Cause (Final disease or condition resulting in death) a. Attlefoscier torc card or condition resulting in death)	2010200000				
	Ļ	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
	Examiner	C. Due to (or as a consequence of):					
isi_ e b)		events resulting in death) Last Due to (or as a consequence of).				<u> </u>	
Division of Vital Records, P.O. Box 68760, within 24 hours afterding Physician: The law requires that the death certificate be executed within 24 hours after dark The this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	X UNPENDED AMENDED AME	o, 2/14/08 TT				
Box 68760, e death certificate be the attending physic ed for use as the bur	/Mec	IF FEMALE: 23c. If yes, outcome of pregnance	Э =	Ectopic pregna	ancy	23d. Date of de Month	livery Day Year
certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification certification ce	cian	past 12 months?	5 Other (Specify)				
, P.O. Box 6876 res that the death certificat signed by the attending phi	hysi	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not result	ting in the underlying cause	e given in Part I.	23e. Did	tobacco use contribu	te to the cause of death?
b.O. that th		Part II. Other significant conditions contributing to death but not result	ang in the ancenying ease.		1 Y	es 2 No 3	Probably 4 V Unknown
ds, Faquires	Completed by				24a. Wa	opsy prio	ere autopsy findings available or to completion of cause of
e law r e has b ge 2 sho	I di			-			eth? Yes 2 No
ii Re m: Th rtificat tor, pag		25. Was case referred to medical	26.Pla	oce of Death (Check			011 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
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n of ding P After funera		27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year)		Yes 2 No			
ivision I or Attend after death Director:	icati	2 Accident Investigation 28e. Place of Injury - At home	e, farm, street, factory, offic	e building, etc.	28f. Location or Town		or Rural Route Number, City
Div pital or urs afte rral Di	Certification:	determined (Specify)					
Division of Vital Records, To the Hospital or Attending Physician: The law requir, within 24 hours after death. To the The The The Completely filled in by the funeral director, page 2 should		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or and response taked	death occurred at the time. or investigation, in my opin	, date and place, ar ion, death occurred	nd due to the ca Lat the time, da	use(s) and manner a te and place, and du	e to the cause(s)
To th withir To th	Medical	and manner stated. 29b. Signature and title of certifier		ense number		29d. Date signed	(Month, Day, Year)
DV0	=	In noth Fourthall MA	0.	C.M.E.		February 2,	2008
i Slovid		30. Name and Ndras of person who completed cause of death (Item 23	a)	D-W	MD 24204		
10 Par		Pamela E. Southall, MD Assistant Medical Exami	ner 111 Penn Str	eet, Baltimore,	IVID 2 1201		
Regi	itate		x Apartas				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	arylan		artmen			and M	ental Hy	giene Reg. No	7 0 0 8	02925
	Physici	an	1. Decedent's Name (First, Middle, Paul R. Dickhof				inout	0, 1			2. Date of De Month 01-25	ath		3. Time of Death 0223 M
>	/Medic Examin	cal	4a. Facility Name (If not institution, 1008 01d Mountain	give street and number)					Location o	of Death	01-23	4c	. County of Death Harford	0223
Ī	Funeral Director				e (In yrs. 74	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Bi (Month, Da 02-01-	rth a <i>y</i> , Ye <i>ar)</i>		
	Maryland fed at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Harfor	d		y, Town or Lo	ocation							10d. Inside City Limits
9	permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "neturel", or Items 23s or 28s-1 show any follupy or other traumatic event, the Medical Examinar must be notified at another.	Funeral Directo	100. Street and Number 1008 01d Mounta 11. Marital Slatus 1 □ Never Married 2 ☒ Marrie	in Rd North 12. Was Decedent Armed Forces?	<u>l</u> Ever in U.	S. 13.		1085 dent of Hi city Cuba			cify Yes or No Rican, etc.)	U.S.	14. Race - Ameri Black, White,	can Indian,
Maryland 21215-0036	vithin 72 hours and one of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the order of the	Completed by	3 Widowed 4 Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Year or Dates: Education		16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	al Occupa rk done d se retired	ation		ng		Specify: Whit ind of Business/Ir	ndustry
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	1 end 2 should Heelth and Men tem 27 te marke other traumatic		19a. Informant's Name/Relationshi Janet D. Dickhof 20a. Method of Disposition		20b. F	1008	01d	Moun	tain	Rd N		орра	or Town, State, Zi , MD 210 ocation - City or T	085
Baltimore,	permit. Peges Department of Important: If It any Injury or o		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service Li	ecify)		rkwood		tery	0		-2008 imunek			Maryland e of Bel Air
	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that caused his one cause on each lin	the death	n. So not en		e of dyin	g, such as	cardiac o			ir, MD 2	Approximate Interval Between Onset and Death
68760,	/Medical Examiner Ascien and privial-transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c. Due to (or as d.	hus (a conseq	uence of):								
Division of Vital Records, P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours effect death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	Ideath 3	⊒Ectopic pr ☐ Other (sp						23d. Date of deliv Month	very Day Year
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<u> </u>	ysician s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 🗆	ER/Outpatie	nt 3 DC	Othe	0.0		(Check only ne 5/1/2 Res		6 ☐Other (Spec	ify)
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<u>N</u>	To the Hospital or Attending within 24 hours effer death. To the Funerel Director: After completely filled in by the funer	Certification:									wn, Stat	θ)	rai Route Number,	
	To the Hospital or within 24 hours effer To the Funeral Dir completely filled in In	Medical	(Check only 2 ☐ Medical E one)	Physician: To the best xeminer: On the basis o and manner st	f examina		vestigation	, in my o _l	pinion, dea			, date an	d place, and due	lo the cause(s)
	To With	2	29b. Signature and title of certifier	Thums,	NS		290) D (0 263	318		290. D8	ol - 28	-08
	le		30. Name and address of person w	ho completed cause of d	leath (Item	BOH-1	Print)	SP I	Cente	v Dr	ise	A6i	rghon u	1, 21009
	Sta Registr		31. Date liled (Month, Day, Year)	5 2008 ^{32. Re}	ar's Signa	ture	2000	U						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 2008 DANIEL DERNARI PARRAH EARYAR /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CEN7 HESTER RIVER If Under 1 Year If Under 24 Hrs. 8. [HOSPITAL CENTER 8. Date of Birth (Month, Day, Yes 6-21-1940 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 XM 2 ☐ F 67 PA Director 199-32-8138 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or Items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8043 Stone Haven Dr. 21060 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) other than Defense Worker Department of Defense or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If Item 27 Is marked o any Injury or other traumatic eve Helen Mary Darrah 2 Bernard Darrah 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Mrs. Angela Darrah/Wife</u> 8043 Stone Haven Dr.; Glen Burnie, MD 21060 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition February 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Stevensville, MD Chesapeake Cremation 21. Signature of Uheral Service Licensee 22. Name and Address of Facility Singleton Funeral and Cremation 1 2nd Ave. SW, Glen Burnie, MD 21061 Services M01411 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last quence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) physician sthe burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 2 DER/Outpatient 3 DOA 4 Nursing Home ို 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 14 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 24 and manner stated. 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

DAVB

Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Henriette L. Env 45 AM /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number, Examiner 4b. City. Town, or Location of Death If Under 24 Hrs. 8. Date of Birth ge (In vrs. last birthday) 9. Birthplace Country) **Funeral** (State or Foreign 105-16-9099 1 □ M **XX**F Months Days Hours Min. July 6,1 920 87 Director New York Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits "natural", or items 23a or 28a-f shov MD Harford Joppa Director 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1030 Hollingsworth Road 21085 **USA** Funeral filed within 72 hours after death Hygiene. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 XXes 2 If Yes, Give Year or Dates: 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: ò Specify: white 3 Nidowed 4 ☐ Divorced er than "natura the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 1 and 2 should be filed w Health and Mental Hygie vm 27 is marked other ti 12 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menia Important: If item 27 is marked any injury or other traumatic ev Frank Herman Marie Skalak 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Service -nephew 1725 Heatherwood Way-Sykesville, Maryland 21784 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State EVANS FUNERAL CHAPEL AND 1 ☐ Burial 2 XX emation 3 ☐ Removal from State Feb 4, 2008 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) CREMATION SERVICES Belair 21. Signature of Funeral Service Licenses 22. Name and Address of Facility EVANS FUNERAL CHAPEL 3 Newport Drive AND CREMATION SERVICES Forest Hill, MD Len 21250 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** testahi /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) certificate be executed and Due to (or as a consequence of): Records, P.'O. Box 68760. attending physician for use as the buria Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknow Part I. Other significant confitions contributing to Jeth but Intresulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 22 No 3 Probably 4 ☐Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ②☑ No certificate has page 2 autopsy ₽Æ No **Division or Vital** 1□ Yes 2 **∑**′No Hospital or Attending Physician: 25. Was case referred to medical examiner? the funeral director Be 26. Place of Death (Check only one) Other: Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ EB/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 Natural hours after death uneral Director: 2 Accident 1 Yes 2∏No 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature 29c. License number 29d Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year

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istrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00763 State of Maryland / Department of Health and Mental Hygiene Mariah Hope Edmisten 1- For State Certificate of Death Reg. No Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 0345 hrs MARIAH HOPE EDMISTEN January 28, 2008 Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital N/A 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) 22 Days 3 Months 6. Sex 5. Social Security Number **Funeral** Foreign Maryland Days Min. Hours Months Davs Oct. 6, 2007 Country Director 218-79-9148 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 Yes 2 X No Maryland Anne Arundel Baltimore 23a or 28a-f show notified at once, Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 613 Waterview Drive 21226 14, Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 X Never Married 2 Married 2 X No Yes White Yes 2 X No specify: Specify: Pages I and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. If Yes, Give Year 3 Widowed Divorced ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) None None 0 n 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Alena Mariah Clyde Allen Edmisten Keith If item 27 is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 613 Waterview Drive, Baltimore, Maryland 21226 Clyde Allen Edmisten 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore. crematory or other place) Burial 2 X Cremation 3 Removal from State Bayview Crematory 02-01-08 Baltimore, Maryland Donation 5 Other Specify: Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart -21. Signature of Funeral Service License injury 21225 rval **Physician** Between Onset and failure. List only one cause on each line Death **ledical** a. Sudden infant death syndrome (SIDS) Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical X UNPENDED attending physician a #Z5a,27,perME,g877, 3/5/08 TT Box 68760, 23d, Date of delivery 23c. If yes, outcome of pregnancy IE EEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown q Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 V Unknown \$ Completed Records, 24b. Were autopsy findings available 24a. Was an After this certificate has been s funeral director, page 2 should prior to completion of cause of autopsy death? performed? No 1 🗸 Yes 2 ✓ Yes 2 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medica Division of Vital Be Other: Nursing Home 5 Residence 6 Other: Hospital: 1 Inpatient 2 DOA ER/Outpatient 3 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: Yes 2 No 1 X Natural Pending Director: 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 2 Wilder Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 29, 2008 O.C.M.E. 30. Name and address of person who completed cause of eeath (Item (23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D.

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month, Day, Year)

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1 Pres 2 No 95 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -11. Marital Status 1 Never Married 2 Married 0 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify 3 ☐ Widowed 4 ☐ Divorced ear or Dates: 16a. Decedent's Usual Occupation (Give kind of work done/during most of working the. DO NOT use retired 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementa //Sacordary (0-12) College (1-4or 5+) portatro or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill thent of Health and Mental H tant: If item 27 is marked ot THORA 7610 20c. Location 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 Doylation 5 Other (Specify) 21. Signature of Funeral Service License Part1. Enter the disease, or complications that is used the death. Do not enter the shock, or heart failure. List only one cause on Jich line. such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury NOVED BY MEDICAL EXAMINES Examine physicien end the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9□ Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 No 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 XYes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manuar of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division Injury 5 Pending death. M 1 Tes 2 No investigation within 24 hours after death To the Funerel Director: / completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and making as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) FEB 0 5 Registrar's Signature 3 Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	t end leeith om 27 ther to		Joan Fugate Spouse 501 94 Steet L 20a. Method of Disposition 20b. Place of Disposition (Name of	Date		Location - City or T	own. State	
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3.18	5 = 7 >	dicai	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of	place, and due to occurred at the til	tne cause me, date a	(s) and manner as and place, and due	to the cause(s)	
	To the Hos within 24 hr To the Fun cumpletely	Ψ	one) manner stated.		1004 5	Data signed (Mant)	Day Vanel	
	1 × 1 × 1 × 1 × 1 × 1 × 1 × 1 × 1 × 1 ×	Σ	29b. Signature and title of certifier 29c. License number	2.	290. 1	Date signed (Monti	i, Day, real)	
			1 XIM M = 1 W645 8	7	\perp \propto	1-4-2	800.	
	10		3/A Nam and address of person to correct cause of death (item 23a) (Type, Print)	71		2 2	1611	
4 5	Y		Harland levels 7733 Hrallhwan 1/NWC	Derlu	in 1	nn 2	1811	
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature					
	Registr		FEB 0 5 2008					

DHMH 17 Rev 1/2001

State

Registrar

6:25 р.ш

FEBRUARY

MARY

Caralle)

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. EDDIE NAKHUDA

05

31. Date filed (Month, Day, Year)

			For State Registrar	State of Maryland		artment of H				08 02932
0.74		W)	Decedent's Name (First, Middle, Last	st)				2. Date of Dea	th	3. Time of Death
	Physici /Medic		Douglas Alfi	ed Feldwick				Februar	y 3, 200)B 2:30 a M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat	h	4c. County of	of Death
			Stella Maris			Timo			Balti	
	Funeral Director		5. Social Security Number 6. S 212–30–3509	ex 7. Age (In yrs. las	st birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.		, Year)	9. Birthplace (State or Foreign Country) England
	pu v		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Lo	ocation				10d. Inside City Limits
	shov shov	5	Maryland Baltimor		noeni					1 □Yes 2□No
	the N	Director	10e. Street and Number	- 11	106117	10f. Zip Code			10g. Citizen of W	
	with the s	Ö	9 Wetherbee Cou	ırt		21131			USA	
	ms 2:	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S	Specify Yes or No-		- American Indian, c, White, etc.
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	1 ☐ Yes 2 No	Specify:	to racari, etc.	Specify:	
21215-0036	2 hou atura cal E	ted	15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occup	ation	rking	16b. Kind of Bu	siness/Industry
215	hin 7.	Completed	(Specify only highest gra	College (1-4or 5+)	life.	DO NOT use retired	d) -	rking		
21	ygien gien er the	į		4	Elect	trical En				Corporation
nd	should be filed withi ind Mental Hygiene. s marked other than umatic event, the M	Be	17. Father's Name (First, Middle, Last			i		me (First, Middle,		
yla	ould Men arke	မ	Alfred	Feldwick	401 14 10	A 1.1 (Q1	Flore		Thornto	
Maryland	12 sh h and 7 Is m raum		19a. Informant's Name/Relationship (ng Address <i>(Street</i> therbee C			-	
	1 and Health em 27		Raymond D. Feldwi 20a. Method of Disposition			osition (Name of matory or other place		oenix, Ma		City or Town, State
Baltimore,	permit. Pages 1 and 2 and 2 and 2 bepartment of Health a Important: If item 27 is any injury or other trauonce.		1 ☐ Burial 2 ☑ Cremation 3 ☐	JRemoval from State				/00	T	Manual and
Ē	artme artme ortani Injury		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Light			Service C 2. Name and Addre		/ U 0		Maryland Vork Road
Ba	Depar Depar Impor any Ir		15-01		Rı	ick Towso	n Funera	l Home.		on Md.21204
	Physician /Medical Examiner		23a. Part1. Enter the distase, or conshock, or heart failure. List in Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a course)	4/2	10000	-/	2 / 2	rest,	Approximate Interval Between Onset and Death
	scuted nd: /	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	ate be executed obysician and the burial-transit	dical Ex	resulting in death) Last							
O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnan 1 ☐ Live birth 2 ☐ Fetal of the pregnant at time of decent section 2 ☐ Fetal of the point of the pregnant at time of decent section 2 ☐ Unknown	death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у		23d. Dat	e of delivery nth Day Year
0	that t ed by detac	F.	Part II. Other eignificant conditions	contributing to death but not result	ting in the u	underlying cause giv	ven in Part I.	23e. Did to	obacco use conti	ribute to the cause of death?
sp.	requires that the sen signed by th rould be detache	Completed by	1/2 most	/ ed				1 🗆 🗅	res 2□ No	3 ☐ Probably 4 X Unknown
Ö	law req as beer 2 shou	ete						24a. Was		Were autopsy findings available
Re	0 5 0							autop perfo 1□ Yes	rmed?	orior to completion of cause of death? I □ Yes 2 □ No
tal	ician: Th certificate rector, pag		25. Was case referred to medical				26. Place of De	eath (Check only o	- AT	
>	Physician: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 ▼ No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatie	nt 3 DOA Oti	ner: 4 \(\text{Nursing} \)	Home 5 ☐ Resid	dence 6 X IOth	er (Specify) HOSPICE
ō	ding Phys h. After this (funeral dir		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Inju Wo	ry at rk?	28d. Describe	now injury occurr	red
Division or Vital Records,	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ertificatio	2 Accident investigation M 1 Yes 2 No							er or Rural Route Number,
	e Hospita 24 hours e Funera letely fille	edical C	29a. Certifier 1 X Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my know miner: On the basis of examinati and manner stated.	rledge, dea on and/or i	th occurred at the t nvestigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and ma date and place,	anner as stated. and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of Certifier	budi m	>	29c, Licen	se number	54	29d. Date signe	d (Month, Day, Year)
	.0		30. Name and address of person who	completed cause of death (Item	23a) (Type	, Print)				
	13		DR. EDDIE NAKHUDA				'IMONIUM.	MD 2109	3	
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signati		and s				

DHMH 17 Rev 1/2001

FEBRUARY 3, 2008 2:30 a.m.

DOUGLAS FELDWICK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Eleanor Fields /Medical 2008 0640 February 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Boyview Medical Center Baltimere If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** 8. Date of Birth
(Month, Day, Year)
Jan. 1,1924 9. Birthplace (State or Foreign Months Hours 1 ☐ M 2 ☑ F Davs Country) Maryland 219-12-8397 Director Jan. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Director 1 ☐ Yes 2 1 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or "natural", or items 23a dicai Examiner must I 212 Parkwood Road 21222 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2≦ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3€Widowed 4 ☐ Divorced Specify: White Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 7 Years Housewife Own Home Pages 1 and 2 should be filed inent of Health and Mental Hyginnt: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Brockington Theodosia Keen 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Fields (Son) 212 Parkwood Road Dundalk, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 2/6/2008 4 □ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signatur ige Licefise 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Radf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eachdine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Stroke 1 month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying frame (.) list are first that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as nse IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) Day Year signed by the a 4□Pregnant at time of death ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has 24a. Was an page autopsy certificate 1∐ Yes 2 No Physiclan: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 No 1 Inpatient ည 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res - 600 tebruary 1,2008

7

Registrar
DHMH 17 Rev 1/2001

State

Eastern Avenue

82. Registrar's Signature

Baltimore, MD 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yolanda Chik 4940

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 8:30 A M **Physician** 2008 Betty Jane Ferber /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Good Samaritan Nursing Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months Days 1 □ M 2 1 X F 219-28-3174 74 03/31/1933 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10h. County 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f show sdical Examiner must be notified at 1 ☐ Yes 2 No Frederick Frederick Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21702 5519 B Old National Pike Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: Specify. þ 3 ☑ Widowed 4 ☐ Divorced Completed marked other than "natur umatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ford Motor Credit Secretary 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Franz Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick, MD 21702 5519 B Old National Pike Kirk Ferber - Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/05/2008 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral prvice Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or light failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUHONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-Box 68760, Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) signed by the a P.O. 1 ☐ Yes 2 🗷 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by DEMENTA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy certificate 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospium.

within 24 hours after death.

To the Funeral Director: After this c ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 🗷 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28987 Keng 30. Name and ad Vess of person who completed cause of death (Item 23a) (Type, Print)

State Registrar SPERLING, M.D.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

5601

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Massy Desmond ffrench-Mullen January 31, 11:25 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9601 Accord Drive Potomac Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min. 1**X** M 2□ F 219-64-5083 89 Yrs. December 9, 1918 Director Jamaica Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location in than "natural", or items 23a or 28a-1 show the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9601 Accord Drive 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status e filed within 72 hours after de la Hygiene. Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) World Bank permit. Pages 1 and 2 should be filed w Depertment of Health and Mental Hygier important: if Item 27 is marked other tr any injury or other traumatic event, that once. 5+ Agronomist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Massy Onge Vincent ffrench-Mullen Edith Dorothy Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lory Walker ffrench-Mullen/wife 9601 Accord Drive, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 3, 2008 ¹ 4 □ Donation 5 □ Other (Specify) Bethesda, Maryland 21. Signature of Fune al Service Licensee 22 Name and Address of Facility.
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Myelettes M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1, there the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive Heart Failure /Medical Due to (or as a consequence of): **Examiner** Atrial Fibrillation Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed as the burial-transit Pulmonary Embolism that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, should be Metastatic Prostate Cancer, Recurrent Plueral 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown been Effusions, Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 🗌 No 1 Yes 2 🔯 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify) 1 X Yes 2 □ No ို funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred Hospital or Attending I 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D23170 February 1, 2008 8001 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gita Bakshi, M.D. 9406 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) 32, Registrar's Signature State FEB 0 5 2008 Registrar

DHMH 17 Rev 1/2001

Physician /Medical Examiner GERALDINE burial-trar attending physician for use as the buria Box 68760 Ö þ σ. signed be be det Records, GUNN page 2 should certificate has I Vital funeral director, this After or Attending death. within 24 hours after death To the Funeral Director: filled in by the

Physician

/Medical

Examiner

Funeral

Director

show

"natural", or items 23a or 28a-f sl edical Examiner must be notified

traumatic event, the Medical

and 2 should be filed within ealth and Mental Hygiene.
n 27 is marked other than

permit. Pages 1 and 2. Department of Health a Important: If Item 27 is any injury or other trau once.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

Examine

Physician/Medical

Be Completed by

Medical Certification: To

Punnam,

FEB 0 5 2008

JYOTHI PUNNAM

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IÉ FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident (Month, Day Year) 5 ☐ Pending Investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

900 S. CATON AVENCE

32 Registrar's Signature

THE STARLE

Registrar

completely

b

DHMH 17 Rev 1/2001

P19925

BALTIMORE,

Feb, 03, 2008

21229

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Charles Leonard Garey, Sr. 4:08 PM February 2, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Baltimore Co. Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1**X** M 2□ F 213-07-2857 89 Maryland July Director 7,1918 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 3a or 28a-f show t be notified at 10a, State 10b. County 10d. Inside City Limits Dundalk Maryland Baltimore 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r Items 23a iner must b United States 21222 1779 Brookview Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1★ Yes 2 ☐ If Yes, Give Year or Dates: "natural", or it edical Exa⊡ine 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Completed by 3 Widowed 4 ☐ Divorced White WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry Inspector 8 Years other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F Be Myrtle C. Krug Charles L. Garey မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Trent of Health ar nt: If Item 27 Is 1 y or other tree (Son) Douglas A. Garey 2458 Chelmsford Drive Crofton, Maryland 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 2/6/2008 Baltimore, Maryland 21. Sign tyre of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Schemic Cardionycpithy 7200 S /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9 Unknown ò signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Sec. 2 1 ☐ Yes 2 🔭 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After t After Injury 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. the within To the 29c. License number 29b. Signature and jittle of certifier 29d. Date signed (Month, Day, Year) 58303 3 2008 FEBRUAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar St. Towson

MO

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32. Registrar's Signature

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31. Date filed (Month, Day, Year) 2008

FEB

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) within 24 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dundalk 2/12 eeser 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

filled in by thin 24 hours a completely

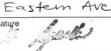
To the within 7 State (Check only one)

29b. Signature and title of certifier

Browner 4940 31. Date filed (Month, Day, Year) 32. egistrar's Signature FEB 0 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated



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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0058893

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29d. Date signed (Month, Day, Year)

Baltimore, MD

31

2008

Registrar

State

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

WASHINGTON ADVENTUT HOSP TAKEMA PARK, MO-20912.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Mamin, MI),

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GREENBERG FEBRUARY 10:30 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL RANDALLSTOWN BALTIMOR 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 08/12/1916 Birthplace (State or Foreign Country) 1 XM 2 ☐ F Months Days 215-09-4168 91 MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits BALTIMORE PIKESVILLE 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 OLD COURT ROAD 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces: 1 ☑Yes 2 ☐ If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify. Specify: WHITE 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MUSICIAN **ENTERTAINMENT** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) REUBIN GREENBERG SARAH PODLES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANN KRESS / DAUGHTER 4703 THREE OAKS RD., PIKESVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State cemetery, crematory or other place) SHAAREI TFILOH CONG. 1 ☐ Burial 2 ☐ Cremation 02/04/2008 BALTIMORE, MD 4 □ Donation 5 ☐ Other (Specify) al Servig 22. Name and Address of Facility SOL LEVINSON & BROS., INC. <u>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> a 1. Enter the disease, or or shock, or heart failure. List only at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death SPIRATION Immediate Cause (r disease or condition resulting in death) PINOMUZY Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner Examine

Physician

Examiner

Funeral

Director

r 28a-f show notified at

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r than "natural", or items, the Medical Examiner m.

n and Mental Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, I

Director

Funeral

Be Completed by

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MD

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

burial-transit Physician/Medical the for use <u>\$</u> Completed page 2 s Be Certification: To

that the death certificate be executed physician ed by the a detached f certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Ithin 24 hours after death.

o the Funeral Director: Af

Division or Vital Records, P.O. Box 68760,

								J,	1 Yes 2] No 3[☐ Probabiy 4	. Wonknown	
										24a. Was an autopsy performed? 1∐ Yes 2 ☑ No	prio d <u>ea</u>	re autopsy findir r to completion o th? Yes 2 No	
25. Was case referred to medical examiner? 26. Place of Deat								ath (Check only one)					
1 Yes 2 No		Hospital:	1 Dinpatient 2 □] ER/Outpatient	3 🗆 [AOG	Other:	4 ☐ Nursing H	ome	5 ☐ Residence 6	□Other (Specify)	
27. Manner of Death 1 □ Matural 5 □ 2 □ Accident	Pending investigation	28a.	Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes			i. Describe how injury			
3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined		Place of injury - At h building, etc. (Speci		et, facto	ory, of	ffice		28f	Location (Street and City or Town, State)	Number o	or Rural Route N	Vumber,
29a. Certifier 1 (Check only 2 N	ertifying Phy ledical Exam	sician: iner: On	To the best of my kn	owledge, death ation and/or inve	occurre	ed at t	the time, o	date and place on, death occu	, and	d due to the cause(s) at the time, date and	and manne	er as stated.	se(s)

S. KHWKITM State

29b. Signature and title of certifier

29c. License number DQQ63430

29d. Date signed (Month, Day, Year) -EBRUARLY 5008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.n

5401 OLD COURT ROAD RANDAUSTOWN

32, Registrar's Signature

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 5 50 Hambrick 2008 PM Gwendoline M. Feb 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Hospital Agnes N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DEC 1 1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Months Days Hours Min 457-09-7416 89 Texas Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 1 ☐ Yes 2X No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 108 Woodlawn Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ XNo Specify: Specify: White 3 ☐ Widowed 4 XDivorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Department Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beckley Henry Bennett Mamie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 108 Woodlawn Avenue, Catonsville, MD Joseph D. Hambrick, Jr. - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 2/4/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Steven H Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD Ju 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) preumonia sep sis with 6 days Due to (as a consequence of): 6 days tibrillation cuantizibi flat conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) mysearchia Due to (or as a consequence of): z dan (23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☑Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2. No.

Physician /Medical **Examiner**

permit. Pages 1 and 2: Department of Health an Important: If Item 27 is any injury or other trau

Physician

/Medical

Examiner

Funeral

Director

a or 28a-f show t be notified at

ral", or Items 23a Examiner must b

Director

Funeral

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Completed

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MD

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

wendolyn

Examine Physician/Medical

physician and stransit signed by t be detach has a ate ha

certifica

within 24 hours a

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Completed

Be 2

Certification:

Medical

State Registrar

law requires that the death certificate be executed

Box 68760.

Vital Records, P.O.

Division or

H wbrick

IF F	EMALE:
23b.	Was decedent pregnant
	in the past 12 months? 1 ☐ Yes 2 Ø No
	1 ☐ Yes 2 ☑ No
	9 Unknown

Baltimore

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 Z No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	
3 Suicide 6 Could not be 4 Homicide determined	
29a Cartifiar 1 Cartifulna Ph	preinier. To the host of my knowledge, death occurred at the time, date and place, and due to the enurcial and manner as attend

(Check only one) 2 Medical Examiner: On the basis of examination and/or investi and manner stated.	gation, in my opinion, death occurred at the tim	e, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

29c. License number mo D58571

Avenue

29d. Date signed (Month, Day, Year) Feb 1 2008

Mary land

ess of person who completed cause of death (Item 23a) (Type, Print)

Tao 900 Caton 31. Date filed (Month, Day, Year) MD 32 Registrar's Signature

2008

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signed by the a peen page 2 certificate this funeral

Physician/Medical þ Completed Be Certification: 29a, Certifier

spital or Attendinours after death.

neral Director: A To the Hospital of within 24 hours at To the Funeral D

Division or Vital Records,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death

State Registrar

6BMC 31. Date filed (Month, Day, Year)

2 No

5 Pending investigation

6 ☐ Could not be

determined

1 Tes

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28h. Time of

Injury

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

7:37 p

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

3 Probably 4 □Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 □ No

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes

6 ☐Other (Specify) [

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 No

2 No

28d. Describe how injury occurred

24a. Was an

1□ Yes

26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence moth

Year

1 ☐Yes 2X No

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day Year)

and manner stated.

ules St. Balto. md Z1 Z0 x 6701 N. Cli

32 Registrar's Signature 05 2008

Registrar

State

Dr. Brian Silveman

FEB

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31. Date filed (Month, Day, Year)

Baltimore, Muyland 21224

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Eastern /

32.

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

FEB 05

2008

Jennifer K. Wormuth 9000 Franklin Square Drive Baltimore, MD

32 degistrar's Signature

			1 - For State Registrar	State of	Marylar		artment of H <i>rtificate of L</i>		Mental Hy	/giene Reg. No.	200	8 0291
	Physic	ian	1. Decedent's Name (First, Mi						2. Date of D	eath	<u> </u>	3. Time of Death
	/Medi	cal		F. Henkelman					FERRU			
	Exami	ner	4a. Facility Name (If not institu 5 a i n t Jos	eph Medica	al Cei	nter	4b. City, Town, or	Location of Deatl		4c.	County of Dea	th Ltimore
1.00	uneral irector		5. Social Security Number 179–20–7072	6. Sex 7		. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, D	ay, Year)		thplace (State or Foreign ountry)
D			Usual Residence of Decedent		140-0				May 1	, 192	28 Nev	Jersey
Maryla	f shov ed at	ō	10a. State	nty ltimore	10c. CI	ty, Town or Lo	cation Nerville					10d. Inside City Limits 1 ☐ Yes % No
h the l	r 28a- notifi	Director	10e. Street and Number	TOIMOTO			10f. Zip Code			10g. Citi	zen of What Co	
ath wit	23a o ust be		10 Weston C	ourt			21093			Of	zen of What Co ited St Americ	
d 21215-0036 filed within 72 hours after death with the Maryland Hydiene.	Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2反 № 3 □ Widowed 4 □ Divord	If Yes (aive	es?		Was Decedent of Hi fYes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		14. Race - Ame Black, Whit Specify: Whi	erican Indian, te, etc.
5-0 72 bo	"natur dical J	eted	15. Deced (Specify only hig	lent's Education thest grade completed)		16a. Deced	dent's Usual Occupa kind of work done o DO NOT use retired,	ation during most of wor	rkina	16b. Kii	nd of Business	/Industry
within ene.	than he Me	Completed	Elementary/Secondary (0-12		or 5+))	9			
e filed	other vent, t	Be C	17. Father's Name (First, Midd			110	menaker	18. Mother's Nan	ne (First, Middle	L Re , Maiden	sidence Surname)	2
Yal ouid b Ments	arked atlc e	70 E	Harry N. Fl.						arie Dep			
Mar d 2 sh th and	7 is m traum		19a. Informant's Name/Relatio				g Address (Street a					
s t and Healt	item 2 other	13	Henry G. Henke		20b. F	Place of Disno	Weston Co sition (Name of		uthervil Date	le,	Marylan	Id 21093
imo Page nent o	ant: If ary or		1 ☐ Burial 2 反 Cremation 4 ☐ Donation 5 ☐ Other	n 3 □Removal from St (Specify)	410	Evans	natory or other place Funeral Bel Air	Febr	ruary	Fo	rest Hi	11, Maryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aff Department of Health and Mental Hydiene.	Importa any inj		21. Signature of Funeral Servi	ce Licensee		Pe.	Name and Addres aceful Al	s of Facility ternativ	es Fune	ral	&Cremat	ion Ctr. P 7
-	10		23a. Part1: Enter the disease	or complications that cau	sed the deat		2325 York	Road T	un i mon i um	I. Ma	ryland	21093 Approximate Interval Between
Phy	sician	9 1	Immediate Cause (Final disease or condition	ist only one cause on eac	n line.		TION CH				-	Interval Between Onset and Death 2 WEEKS
	edical miner		resulting in death)	Due to (or	as a conseq	uence of):	ISEASE					
		er	Sequentially list conditions, if any, leading to immediate	t	as a conseq		TOEMOC					·
A be	ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1		, ,						
68760, Kificate be executed	physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or	as a conseq	uence of):						
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.O. Box the death cer	by the attending	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		h 2 ☐ Feta It at time of d	ıl death 3□	Ectopic pregnancy Other (specify)			2	3d. Date of del Month	ivery Day Year
S, P	igned be de	by P	Part II. Other significant cond			ulting in the un	derlying cause give	n in Part I.	23e. Did t	obacco us	se contribute to	the cause of death?
Hecords, ne law requires t	should	eted	_ACUTE MYOCARI	DIAL INFARCT	ION				10	Yes 2 X]No 3∏Pr	obably 4 □Unknown
He faw	certificate has l rector, page 2 s	Completed							24a. Was auto	DSV	24b. Were au prior to death?	topsy findings available completion of cause of
	certificat rector, pa	Be Cc	25. Was case referred to medi	cal				26. Place of Dear		ormed? 20 No		2 No
. >	0 0	10 B	examiner? 1 ☐ Yes 2X No	Hospital: 1 💢 Inp	atient 2	ER/Outpatient	0.11		ome 5 ☐ Resi		□Other (Spec	cify)
	After thi funeral		27. Manner of Death 1 XNatural 5 ☐ Pendinyo	28a. Date of I ding (Month, stigation	njury <i>Day Year)</i>	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe			
tten deat	to the	Certification:	3 Suicide 6 Coul	d not be 28e. Place of	injury - At ho	ome, farm, stre	et, factory, office	es 2□No	28f. Location (Street and	Number or Ru	ıral Route Number.
uital or	ral Dir		- Information	building,	etc. (Specify				City or Tou	vn, State)		
To the Hospital or A within 24 hours after a	To the Funeral Direc	edical	29a. Certifier 1 X Certify (Check only one) 2 Medic	ving Physician: To the be al Examiner: On the basi and manner	s of examina	wledge, death tion and/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occur	, and due to the rred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
Within	To t	Ž	29b. Signature and title of certi	fier	un		29c. License			29d. Date	signed (Month	n, Day, Year)
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	Registra	ar	FEB 0	5 2008	yes d	9 A	3452					

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			1 _ State	State of Mar	•	Certificate of			ornar rry	Reg. No.	2008	3 02947
			Registrar 1. Decedent's Name (First, Middle, Last)			70717770410 01			2. Date of De			3. Time of Death
	Physici		11 11	000		1114			Month	Day	2007 8	ZZ 54 M
	/Medio Examin		4a. Fecility Name (If not institution, give st		- (1	4b. City,/Jown,	or Location	of Death	S(1) (County of Dea	
	Examin	iei	The John Ho	ophins Ho	noital	1Da	Itin	10 K	City	1		
	Funeral		5. Social Security Number 6. Sex	7. Age (/	n yrs. last birthe	Months Days	If Under		8. Date of B	rth av. Year)	9. Bir	thplace (State or Foreign buntry)
	Director		219–40–3734	M 2□F	62 Yr	s. Northis Days	110010		12/04	/1945	MAI	RYLAND
	p ,		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town o	or Location						10d. Inside City Limits
	show show	5	MD N/A	"		LTIMORE CI	TY					1 X Yes 2 □ No
	he M	ecte	10e, Street and Number			10f. Zip Code				10a. Citi	zen of What Co	puntry?
	a or 3	Funeral Director	2012 E. NORTH AVE	MIE			21213			US		,
	leath	era		2. Was Decedent Eve	er in U.S.	13. Was Decedent of If Yes, specify Cub		igin? (Spe	cify Yes or No		14. Race - Ame	
(0	r iten	Ξ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No					Rican, etc.)		Black, Whit	
93	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f ehow fra Madical Examiner must be notilled at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Spесту:				Specify: B	JACK
5-0	natu	Completed	15. Decedent's Education (Specify only highest grade	ation completed)	16a. D	ecedent's Usual Occu Give kind of work done fe. DO NOT use retire	pation during mos	st of worki	ng	16b. Kii BETH	LEHEM S	Industry
21	hen.	mpje	Elementary/Secondary (0-12)	College (1-4or 5+)		ife. DO NOT use retire 'EEL WORKER					ORATIO	
7	Hygien Hygien Sthertl		11TH 17. Father's Name (First, Middle, Last)		3,1	EEL WORKER	1	er's Name	(First, Middle	. Maiden	Surname)	
and	ntal h	Be c	HOWARD HURTT				140		VILLIAN			
7	should ind Men ind marke umatic	မ	19a. Informant's Name/Relationship (Typ	e. Print)	19b. N	Mailing Address (Street					r Town, State,	Zip Code)
Maryland 21215-0036	and 2 sealth arm 27 is		EVELYN HURTT / WIE		20	12 E. NORT	H AVE	NUE,	BALTIN	MORE,	MD 212	213
	F Heal		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other pla			ate		cation - City or	
E 0	Pages nent of ant: If it		1 ☐ Burial 2 【Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		REMATORY	1	02/09	9/08	CAT	ONSVILI	LE, MD
Baltimore,	그는 근 등		21. Signature of Funeral Service Licensee	0/ 0/	V	22. Name and Addre	ess of Facili	ity HO	WELL FU	JNER A	L HOME	21207
m	Depa Impo any is		1 Mullung	101	dolle	_4600 LIBE						
			23a. Party Exter the disease, or complice shock, or beart failure. List only one	ations that caused the cause on each line.	e death. ono	t enter the mode of dy	ing, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Pause (Final disease or condition	CON94	ostrue	Hert Fa						Oriset and Death
8	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of)	1						
	Examiner	_	Sequentially list conditions, b.									
7	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence or)	:						
V	and and II-trar	xan	that initiated events c. resulting in death) Last	Due to (or as a c	onsequence of)	:						
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687			d.									
Вох	leath certificate attending phy I for use as the	/W	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of		20 Estable estables				2	23d. Date of de	
m	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 (3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	-y 				Month	Day Year
P.O.	that the de ned by the a detached f	hys	9 Unknown	9□ Unknown					1 = -1			
S,	res tha igned be del	by Physician/Med	Part II. Dther significant conditions cont	ributing to death but r	not resulting in t	he underlying cause gr	ven in Part I	1.			_	the cause of death?
ord	w require been si should I	ted							10	Yes 21	#NO 3LIP	robably 4 Unknown
ecc	law r las be	pie							24a. Was	PSY	prior to	utopsy findings available completion of cause of
= E	The page	Completed							1 Tes	ormed? 2 No	death?	2 No
Vita	lcian. Sertific ector	Be	25. Was case referred to medical examiner?	spital:		Ot	her		(Check only			
Division of Vital Records,	Phys this al dir	5 To	1 Yes 2 No	1 🗆 Inpatient	2 PER/Outp	alient 3L DOA	4 🗀 141		ne 5 Res 28d. Describe		Other (Spe	ocify)
uo	ding h. After funer	tlon	1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	ear) Inju	iry Wo	ork?]Yes 2. □				,	
İSİ	Atten deat ctor: y the	flca	3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm	, street, factory, office						ural Route Number,
Ö	after after Direct	Certification:	4 Homicide	building, etc. (Specify)				City or To	wn, State	,	
	To the Hospitel or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: Aller this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying Physi (Check only 2 Medical Examine									
	the Hin 24 the Fu	Medicai	one)	and manner stated		/		an occur	ou at the time,			
	To the within 2 To the complet	≥	29b. Signature and title of certifier			1	se number	_ \		29d. Dat	e signed (Moni	in, Uay, Year)
•				- //			70626	38		٦	17/0	8
1	5		30. Name and address of person who con	pleted cause of deat	h (Item 23a) (T	(pe, Print)	al toe	Ω	all m	0.1	MD 2	1217
	* C^	10	31. Date filled (Menth, Day, Year)	32. Registrar's	Signature A	WALL IN	ni /IVC		amm	WH,	1417 /	1/1
	Sta Registr		FEB 0 5 2008	125640	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	A Stanton						

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) HARNSBERGER, SRFEBRUARY **Physician** ROBERT 12:30 AM 2008 /Medical A. Facility Name (If not institution, give street and number)
HALLOR HOLDITAL
3001 LOUTH HANOVER STREET 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 11 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months Days March 19,1926 Maryland 220-24-9883 Director 81 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Baltimore N/A Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21230 1718 Patapsco Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify ģ White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Rod Mill Operater Copper Refinery N/A 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental h eq plnoys Christina Hildwein Harnsberger Raymond ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s 36 East Heath Street Baltimore, Maryland 21230 Health a Robert K. Harnsberger, Jr. (Son) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brooklyn Park, Maryland 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery :02/06/08 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
130 East Fort Avenue Baltimore, Maryland 21230 21. Signature of Funeral Service Licenses Colline John 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line SPIRATORY FAILURE SECONDARY TO Immediate Cause (Final disease or condition CHRONIC OBSTRUCTIVE AIRWAY DISEASE EXACERBATION Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) 2KAG OI **Physician** /Medical Due to (or as a consequence of): 3 WEEKS Examiner ASTROCYTOMA. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 2KAG UI PNEUMONIA that the death certificate be executed burial-tra Due to (or as a consequence of): physician s the buria P.O. Box 68760. Physician/Medical attending pt IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed certificate 2 No 1∐ Yes Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation within 24 hours after occ...

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D 000 theory were RES 2008 FEBRUARY 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ONITE IHEAGWARA, 2001 S. HANIOUER STREET, BALTIMURE, MARYLAND 31337 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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			For State of Marylar	nd / Department of He		Hygiene 2000 0201
			Registrar	Certificate of D		Reg. No. 2000 029
B	Physic	ian	1. Decedent's Name (First, Middle, Last)	arai a	Mont	
7. S. S.	/Medi		Shirley Marie Har 4a. Facility Name (If not institution, give street and number)	Cris 4b. City, Town, or L	JG00	
	Exami	ner	Baltimore Washington medica		Burne	Anne Arundel
	Funeral	_	5. Social Security Number 6. Sex 7. Age (In yrs.	. last birthday) If Under 1 Year	If Under 24 Hrs. 8. Date	of Birth
	Director		232-68-9754 1□M 2⊠F 64	Yrs. Months Days	Hours Min. (Mont	in, Day, Year) Country)
	pur ,		Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ity, Town or Location		
	faryfa sho ed at	0	Maryland Anne Arundel		Burnie	10d. Inside City Limits 1 □Yes 2∑No
	the N 28a-1 notifi	Director	10e. Street and Number	10f. Zip Code	Durine	10g. Citizen of What Country?
	3a or	Ö	1033 A Bell Ave.	Tot. Zip Code	21060	United States
	death ms 2 r mus	Funeral	11. Marital Status 12. Was Decedent Ever in L	J.S. 13. Was Decedent of His	panic Origin? (Specify Yes , Mexican, Puerto Rican, etc	
9	after or ite mine		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2分 No If Yes, Give	If Yes, specify Cuban 1 □ Yes 213No		271.11
003	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notifled at	d by	3€ Widowed 4 Divorced Year or Dates:	TEL TES ZETNO	Specify:	Specify: White
5	"nata	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired)	tion uring most of working	16b. Kind of Business/Industry
12	within iene. than "	를	Elementary/Secondary (0-12) College (1-4or 5+)			Dallaimana Garantas
9	filed Hygi other ent, the		12 Years 17. Father's Name (First, Middle, Last)	Crossing Gu	1a.r.u 18. Mother's Name (First, M	Baltimore County
an	Mental Mental arked o	To Be	Russel Heater		Audrey Ma	*
Maryland 21215-0036	2 should and Men is marke aumatic	_	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street ar		Number, City or Town, State, Zip Code)
	rt 23 mg		Jonathan Norwig, Jr. (Companion	P.O. Box 957	Millersville	e, Maryland 21108
ore	ges 1 a t of Hea of othe		20a. Method of Disposition 1 ☐ Burial 22℃cremation 3 ☐ Removal from State	Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
tim	tmen tant: lury		4 □ Donation 5 □ Other (Specify) Hi	lltop Service Co		Towson, Maryland
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licensee	22. Name and Address Duda-Ruck 7922 Wise	Funeral Home	of Dundalk, Inc. k, Maryland 21222
	1 to 1		23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	th. Do not enter the mode of dying,	, such as cardiac or respirate	tory arrest, Approximate Interval Between
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7	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	\n \h	5.10	TUtaction
V,	execu n and ial-tra	Exar	that initiated events resulting in death) Last C. Due (or as a consequence)	quence of):	218	
68760,	ficate be executed physician and s the burial-transit	edical				
		Medi	IF FEMALE:			
Box	death certifi e attending d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnat 1 ☐ Live birth 2 ☐ Feta			23d. Date of delivery
	0 0 0	/sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of d 9 ☐ Unknown 9 ☐ Unknown	death 5 ☐ Other (specify)		Month Day Year
P.0.	ires that the de signed by the a be detached t		Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given	in Part I 23a	Did tobacco use contribute to the cause of death?
or Vital Records,	requires that the een signed by th nould be detache	d by	a country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the coun	and girt the underlying eduse given	11	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown
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>	nysici nis cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐	ER/Outpatient 3 DOA Other:		Residence 6 Other (Specify)
	ng Pł fter tf	:uc	27. Manner of Death 1 Natural 5 ☐ Pending (Month, Day Year)	28b. Time of 28c. Injury a Work?		ribe how injury occurred
sio	tendi eath. tor: A the fu	catic	2 Accident investigation	M 1 □ Ye	es 2 🗆 No	
Division	or At fiter d Direct in by	Certification:	4 ☐ Homicide determined 28e. Place of injury - At he building, etc. (Specify	ome, farm, street, factory, office fy)	28f. Locati City o	ion (Street and Number or Rural Route Number, or Town, State)
_	spitai ours a neral I filled		29a. Certifier 15 Certifying Physician: To the best of my kno	Wledge death occurred at the time	date and place and division	a the equec(a) and a
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only one) Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check only one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check o	ition and/or investigation, in my opir	nion, death occurred at the t	time, date and place, and due to the cause(s)
	To th withir Comp	Me	29b. Signature and title of certifier	29c. License n	number	29d. Date signed (Month, Day, Year)
)			Will X MITH	My DG	1418	1/31/08
	6		30. Name and address of person who completed cause of death (Item			01061
				son Park Drive	Glen Burnie,	MD 21061
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signal	iture		
	riegistr	AI .	FEB 0 5 2008	1		

				State of M	aryland	d / Depa	rtment o	of Health	and Me	ental Hy	giene			
		1	For State Registrar					of Death			Reg. No.	008	0.2	950
			Decedent's Name (First, Middle, La	ist)						2. Date of Dea Month	ath Day	Year	3. Time of	Death
	Physicia		JAMES	S		HEAR				FEBRUAN	43	2008	12:35	TM
e Program	/Medic		4a. Facility Name (If not institution, giv	e street and number	r)		4b. City, Tov	wn, or Location				ity of Death		
			JOHNS HOFKINS BAYVIE		H CE	NTER	If Under 1 Y			8. Date of Birt	N,		lace (State o	r Foreian
	Funeral		o. dodan dodaniy	Sex 7. A 1.1∑ M 2F	Age (In yrs. I	a <i>st birthd</i> ay) Yrs.		ays Hours	Min.	(Month, Da	y, Year) 0,1955	Coun	yland	
ű.	Director	-	212-76-1708 Usual Residence of Decedent		52					Aug. Z	0,1000			
3	and the same	- H	10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside Ci 1x∑Yes	
	Mary -f sh fied s	ţō	Maryland N/F	4					Balti	more C	ity			20140
:	r 28a	Director	10e. Street and Number				10f. Zip Co	ode			10g. Citizen o			
	23a o		23 South Kres				212			W. W		d Stat		
	hours affer death with the maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	Funeral	11. Marital Status	12. Was Deceder Armed Forces	s?	S. 13.	Was Deceden If Yes, specify	t of Hispanic C Cuban, Mexic	ingin? (Spe an, Puerto f	city Yes of No Rican, etc.)	В В	lack, White,		
0	or It	by Fu	1 ☑ Never Married 2 ☐ Mamed 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ⅓ If Yes, Give Year or Dates	_		1 ☐ Yes 2K	No Specif	y:		Spe	cify:	Whit	e
500	hours tural'	g p			-	16a. Dece	dent's Usual C	Occupation			16b. Kind of	Business/In	dustry	
<u>.</u>	n 72 n "naf ledici	Set	15. Decedent's E (Specify only highest gi	rade completed) College (1-4c	or 5+)	(Give life.	kind of work of DO NOT use i	done during mo retired)	ost of workii	ng				
7	with jene. r thar the N	Completed	Elementary/Secondary (0-12) 12 Years	College (1-40)	Di	sabled				N/A			
	e filed Il Hyg other	Be C	17. Father's Name (First, Middle, Las	it)						•	, Maiden Surr	name)		
/iand	uld be Jenta rked tic ev	To B	Howard J. Her							Harler			0-4-1	
Mary	and had sand had sauma		19a. Informant's Name/Relationship		>	19b. Maili	ng Address (S	Street and Num	nberorRum n Dris	al Route Numb 7⊖ Ba1	timore	wn, state, zij • Mars	land	21224
e, E	and 2 ealth n 27		Mrs. Cleta Herrin	ng (Mothe			osition (Name			Date		on - City or T		
ore	ges 1 t of H if Iter or oth		20a. Method of Disposition	☐Removal from Sta	ate C	cemetery, cre	matory or other	er place)	2/0/	2000	Crai	gsvill	e 172	
<u>=</u>	tmen tant:		4 □ Donation 5 □ Other (Spec		Co		y Mem.	Address of Fac	2/8/2					
Baltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	ensee	<	-	Duida-E	Ruck Fu	néral	Home o	of Dund , Mary	alk, I land	Inc. 21222	
			23a. Part1. Enter the disease, or co	mplications that cau	sed the deat	th. Do not en							Approxima Interval Be	ite etween
	Line		shock, or heart failure. List on Immediate Cause (Final	ly one cause on each	n iine.			cutto				2 NICH	Onset and	Death NKNO/
1000	Physician /Medical		disease or condition resulting in death)	a. HYPEND Due to (or	as a consec		HEROS	<u>scure</u>	110	YEDOV	(31.701-01)	13120	30	NENCO
	Examiner													
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V	cuted od ansit	Examiner	that initiated events	c										
760,	te be executed ysician and ie burial-transit		resulting in death) Last	Due to (or	as a consec	quence of):								
376	eath certificate be executed attending physician and for use as the burial-transit	lical		d										
x 68	The law requires that the death certifical ate has been signed by the attending phinage 2 should be detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, outco	me of prean	ancv					23d.	. Date of deli	very	
Вох	ath c attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	th 2 ☐ Fet	al death 3	☐Ectopic pre					Month	Day	Year
o.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknow										
Q	that the de led by the a detached f	H.	Part II. Other significant condition	s contributing to dea	th but not re	sulting in the	underlying ca	use given in Pa	art I.	23e. Did	tobacco use			
Sp	uires sign ld be	d by								1	Yes 2	lo 3□Pr	obably 4]Unknown
CO	w requires that s been signed to should be deta	Completed								24a. Wa	s an 2	4b. Were au	topsy finding	s available cause of
Re	he lav e has age 2 :	E G								per 1□ Yes	formed?	death? 1 □ Yes	2□No	
Vital Records,	iclan: Th certificate rector, pag	BeC	25. Was case referred to medical					26. Pl	lace of Dea	th (Check onl)	one)			
<u> </u>	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 In	patient 2	□ER/Outpati			Nursing H		sidence 6 [cify)	
יס ר	Attending Physician: The isr death. rector: After this certificate he by the funeral director, page		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month)	Injury , Day Year)	28b. Time Injury		Bc. Injury at Work?		28d. Describ	e how injury o	ccurred		
30	Attending r death. ector: After by the fune	atic	2 Accident investiga				M	1 Yes 2	2 No	28f Location	(Street and N	lumber or Ri	ıral Route Nı	umber.
Division	or Att	Certification:	3 Suicide 6 Could no 4 Homicide determin		g, etc. <i>(Spec</i>	nome, rarm, s cify)	street, factory,	, onice		City or 7	own, State)			,
	Hospital of the hours af Euneral D		29a. Certifier 1 CertifyIng	Physician: To the base	nest of my kr	nowledge, de	ath occurred a	at the time, dat	e and place	, and due to th	ne cause(s) an	nd manner as	stated.	
	Hos 24 ho Fune	Medical	(Check only 2 Medical E	xaminer: On the bas	sis of examir er stated.	nation and/or	investigation,	in my opinion,	death occu	irred at the tim	e, date and pl	ace, and due	e to the caus	e(s)
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Mec	29b. Signature and title of certifier				290.	. License numb	per		29d. Date s	signed (Mont	h, Day, Year)
	- SFO		Xhand	^	M		-	D620	32		FEBR	VARY	3 20	808
	/		30. Name and address of person w	nho completed cause	of death (Ite	em 23a) (Typ	e, Print)							,
	5		JENNIFER HAYA	541 # 4	940 3	EASTE	ed the	ENUE	BA	LTIMO	RE.	MD	2122	4
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	Regis	trar	1 - 1 2 2 3	4				_						

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Marylar	nd / Depa			Mental Hyg	g. No.?	3 02951
Physic /Med Exami	ical	Decedent's Name (First, Middle, Las. Margaret 4a. Facility Name (If not institution, give Genesi's Elderc	M. street and number)	F		n, or Location of Deal		Day Yea	8:15 A M
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USO ours after des aff, or itema	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 MYes 2 ☐ No ff Yes, Give Year or Dates: WW		Was Decedent tf Yes, specify (1 ☐ Yes 2 🔀	of Hispanic Origin? (Cuban, Mexican, Puer No <i>Specify:</i>	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, W Specify:	mencan Indian, hite, etc. White
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Mary land 21215-UU36 nd 2 should be filed within 72 hours at the and Mental Hygiene. 27 is marked other than "natural" or reaumatic event, the Madical Exert	To Be C	17. Father's Name (First, Middle, Last) James	P. Clayto			Mar	<u> </u>	Bra	adley
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Baltimore , bermit. Pages 1 er Depertment of Hee importment if item important: if item sone, energinger of other presents once.		20a. Method of Disposition 1 (X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, cre	osition (Name of other of Ood Cem	place)	Date 2008	20c. Location - City Baltimo	
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Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the deal one cause on each line. PNEVM a	th. Do not en	ter the mode of	dying, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
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VII.	To Be	25. Was case referred to medicaf examiner? 1 ☐ Yes 2 ☑ No	Hospitaf: 1 ☐ Inpatient 2 ☐] ER/Outpatie	ent 3 DOA		eath (Check only on Home 5 Reside		Specify)
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Hospit 24 hour Funer letely filti	Medical		ysician: To the best of my kn niner: On the basis of examin and manner stated.	ation and/or in	nvestigation, in	my opinion, death occ	curred at the time, d	ate and place, and o	due to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier).01. "	.Ω	29c. Li	cense number	2	9d. Date signed (M	onth. Day, Year)
d		30. Name and address of person who		m 23a) (Type	Print)	SILBRIDA	- DA A	ATIMO	Onth. Day, Year) PY 3, 2008 PF, MM) 21231
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	Soul		~0,0	TOIT COL	1

State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 1, 11:15 LAWRENCE E. HADDAWAY, SR. FEBRUARY 2008 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CROWNSVILLE ARUNDEL FAIRFIELD NURSING CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1⊠M 2□F Yrs. 1916 MARYLAND Director 92 24, 215-16-6948 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "nature." 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🕅 No Directo MARYLAND ANNE ARUNDEL MILLERSVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 606 MILLWRIGHT CT APT. 21108 UNITED STATES Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: À 3 ☑ Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) $5\pm$ MINISTER CLERGY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ESTELLE BROWN ٩ LOUIS HADDAWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2004 BILOXI CIRCLE; PLANO, TX 75075 JOYCE TSAO / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5 Other (Specify) 4 Donation PARK 2008 ELKRIDGE, MARYLAND MEADOWRIDGE MEM. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A GLEN BURNIE, MD 21061 421 CRAIN HWY. SE; Part: Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 118mon /Medical Due to (or as a consequence of): **Examiner** rovas au Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (or as a consequence of): The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, attending physicien and Due to (or as a consequence of): Physician/Medical use as tha IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No hes this certificate 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Inpatient 1 Yes 2 No 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation М 215KN0 1 Tyes death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person completed cause of death (Item 23a) (Type, Print) Olin Byrne MD 21061 208 Cra Da Mu 100 31. Date filled (Month, Day, Y 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death LILY HABER JANUARY 31 **2008** 6:30 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARMONY HALL ASSISTED LIVING COLUMBIA HOWARD If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Months 1170571910 AUSTRIA-HUNGARY 97 068-38-1988 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits HOWARD 1 ☐ Yes 2 X No COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6336 CEDAR LANE, #326 21044 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Specify. 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FRENCH TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SIMON WEISS YETTA KAMERLING 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5424 CHATTERBIRD PLACE, COLUMBIA, MD 21045 ANNE SEILER / DAUGHTER 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 3 Remoyal from State BETH DAVID CEMETERY 02/03/2008 ELMONT, NEW YORK 5 ☐ Other (Specify) 22. Name and Address of Facility of Furteral Ser SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Sequenticity list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 20 No 26. Place of Death (Check only one) er: 4 Nursing Home 5 Residence 6 Nother (Specify)

Physician /Medical Examiner

death certificate be executed

Records, P.O. Box 68760,

Division or Vital

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygene. Important: if them 27 is marked other than "natural", or items 23a or 2 any injury or other traumath.

3altimore, Maryland 21215-0036

Director

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Completed

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Physician/Medical Be Certification: To

ģ Completed

After t within 24 hours after deam.

To the Funeral Director: A'

To the Hospital or Attending

State

25. Was case referred to m examiner?								
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27. Manner of Death 1 ☑ Natural 5 ☐ P	Pendina	28a.	Date of Injury (Month, Day Ye	ear)	28b. Time of Injury		28c.	Injun
	rvestigation					M		1 🗆 🕆
	Could not be letermined	28e.	Place of injury	- At h	ome, farm, stree	t, fact	ory, of	fice

at Yes 2 □ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 💆 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29d, Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

0

30. Name and address of person who co

4 Homicide

(Check only one)

29a. Certifier

Registrar's Signature

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 3:16 PM John B. Imboden 2 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 111 West Lake Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Days Hours 212-36-0678 1√M 2□F 9/17/1925 Arkansas Director Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 111 West Lake Avenue 21210 death w America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑XYes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Psychiatrist Psychiatry permit. Pages 1 and 2 should be filled we Department of Health and Mental Hygien Important: if Item 27 is marked other the any Injury or other trainmant. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Imboden Landreth Baskerville 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne G. Imboden/ spouse 111 West Lake Avenue Baltimore, Maryland 21210 20b. Place of Disposition (Name of cemetery crematory of other place)
Evans Funeral Date 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 5, 2008 4 ☐ Donation 5 ☐ Other (Specify) Chapel- Bel Air 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P. A
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the m shock, or heart failure. List only one cause on each line. e of dying, such as cardiac or respiratory arrest, Immediate Cause (Final ue to (or as a conseq e) ce of): **Physician** disease or condition resulting in death) 0 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-trai Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? ō Month Year 4⊡Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. the 9□Unknown 9 T Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Q No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 : autopsy performe Yes certificate 2 No 1 TYes Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) A No Other: 4 Nursing Home Besidence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 1 Inpatient this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After (Month, Day Year) To the Hospital or Attending 17 Natural 5 Pending investigation 1 □ Yes 2 □ No Accident completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1// Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and tit

30X

State Registrar 31. Date filed (Month,

Jay, Year) 32. Registrates Signatu



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02955 Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Allen Paul Jones 11: 04 AM 29 January 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner St. Agnes
Social Security Number Baltimore Hospital 8. Date of Birth Mar . 16, Year 943 Mary Land If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. **214-44-**8478 1**X** M 2□ F 64 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Baltimore, Maryland 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Marylament of Health and Mental Hygiene. 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD Howard Wood Bine 10g. Citizen ot What Country? 10e. Street and Number 10f. Zip Code 21797 U.S.A. 15025 Martlock Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 XNever Married 2 Married 1 ☐ Yes 2 ☒ No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Mechanic marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Geraldine Alvera Guercio John Paul Jones ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>(0)</u> Department of Health ar Important: If Item 27 is any Injury or other trau Linda Martlock/Sister 15025 Martlock Drive Wood Bine MD 21797 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition West Arundei Crematory 2-4-2008 1 ☐ Burial 2 X Cremation 3 ☐Removal from State Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature ot Funeral Service Licensee Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne Md 21228 Kepu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 20 days **Physician** Cholangio sarcoma /Medical Due to (or as a conseque Examiner Encephalogalhy as a consequence (): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cor Examine Hospital or Attending Physician: The law requires that the death certificate be executed baclerenie Due to (or as a consequence ot) Division or Vital Records, P.O. Box 68760, physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause ot death?
1 ☐ Yes 2▼ No 24a. Was an autopsy performe certificate 1□ Yes 2 No 25. Was case reterred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 4 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certitier (Check only one) and manner stated. the 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier January 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Dichhuona 31. Date filed (Month, Day,

Year)

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2008

32. Registrar's Signature

Baltimore,

			For State	State of	Maryla	-	artment rtificate				lental Hy	/	806	02956
		_	Registrar 1. Decedent's Name (First, Middle,	aet)			Timeate	OIL	Jean		2. Date of De	Reg. No.		3. Time of Death
п	Physici	an	Kenneth	_asi/			Jacks	ron.			Month January	Day	008^{Year}	12:30 A M
2	/Medi		4a. Facility Name (If not institution,	in street and nur	ahor)		4b. City, T		Location	of Death	Januar	-	ty of Death	
	Examir	er	Bradford Oaks N		,		Clir			or Boatt				orge's
	Funeral			. Sex		s. last birthday) If Under 1	l Year	If Under		8. Date of Bir	th	9. Birth	place (State or Foreign
	Funeral Director		228-28-6116	1X M 2□F	79	Yrs.	Months	Days	Hours	Min.	July 28	, 1928		intry) ginia
			Usual Residence of Decedent								1		1	
	how at		10a. State 10b. County		10c. C	ity, Town or L	ocation							10d. Inside City Limits 1X Yes 2 □ No
	e Ma la-f s	cto	VA		F	'rederi	cksbur	g						
	or 28	Dire	10e. Street and Number				10f. Zip (Code				10g. Citizen of	f What Cou	intry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	Funeral Director	11001 Ascot Ci					407				USA		
	tems er m	nue	11. Marital Status	12. Was Dece Armed Fo	rces?	U.S. 13	Was Decede If Yes, speci	ent of Hi ify Cuba	ispanic Ori an, Mexica	igin? (Sp n, Puerto	pecify Yes or No Rican, etc.))- 14. Ha	ace - Amer ack, White	ican Indian, , etc.
36	s afte , or it amin	by Fi	1 Never Married 2 Married	If Yes, Giv	e		1 ☐ Yes 2	X No	Specify:	:		Spec	ify: B1	ack
21215-0036	hour:	d b	3 Widowed 4 Divorced	Year or Da	ates.	16a Dec	edent's Usual	Occup	ation			16b. Kind of		
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9	filed Hygi other		17. Father's Name (First, Middle, La	ıst)		1100-				er's Nam	e (First, Middle	, Maiden Surna	ame)	
Maryland	2 should be filed w n and Mental Hygie I Is marked other t raumatic event, th	To Be	William Jackson	1					Edn	a Ma	ay Willi	s		
2	shound Mind Mind Mind Mind	-	19a. Informant's Name/Relationship	(Type. Print)		19b. Mai	ling Address	(Street	and Numb	er or Ru	ral Route Numb	er, City or Tow	n, State, Z	ip Code)
	s 1 and 2 should be filed within 72 ho I Health and Mental Hygiene. Item 27 is marked other than "natun other traumatic event, the Medical		Selma C. Willia	ms-Wife		1100	1 Asco	t C	irc1e	. Fr	ederick	sburg,	VA	22407
ā,	s 1 and 2 f Health item 27 l		20a. Method of Disposition		i	Place of Disp	osition (Nam	e of			Date	20c. Location		own, State
9	Pages 1 nent of H ant: If Ite ury or ot		1 ☐Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		l G	ood Ho emeter	oe .	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	2-2 -	08	Front	Rova	I. VA
Baltimore,	1 to the first		21. Signature of Funeral Service Li			Cinc CCI	22. Name and	Addre	ss of Facili	ity S	tover F	uneral	Home	Inc.
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7		14	73) Fart . Enter the disease, or c sho 2, or heart failure. List or	omplications that of	aused the de	ath. Do not e	nter the mode	of dyin	ig, such as	s cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final	ily one cause on e	1 16 N	Mus	06	D	u	m	WCIRAS	1		Onset and Death
10	/Medical		disease or condition resulting in death)	aDue to	or as a conse	equence of):	-			1	4000	<u> </u>		71.00401
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or	Physician: this certific ral director,	2	1 ☐ Yes 2 ☐ No			ER/Outpati			4 (A) N	lursing H	lome 5□Res			cify)
n	Affer	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		th, Day Year)		M Z	8c. Injur Wor	yat k? Yes 2.⊑	TNo	28d. Describe	how injury occ	urrea	
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Division	or Ai offer of Direct in by	Certification:	4 ☐ Homicide determin	ed 20e. Flace build	ng, etc. (Spe	home, farm, s	ineer, ractory	, onice				wn, State)	nbei oi riu	rar rioute (vumber,
			29a. Certifier 1 X Certifying	Physician: To the	best of mv k	nowledge, de	ath occurred	at the ti	me, date a	and place	and due to the	cause(s) and	manner as	stated.
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical E	xaminer: On the b	asis of exami ner stated.	ination and/or	învestigation,	in my	opinion, de	eath occu	urred at the time	, date and plac	e, and due	to the cause(s)
	o the	Me	29b. Signature and title of certifier				29c	Licens	e number			29d. Date sign	ne g (Monti	h, Pay, Year)
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	1		20 Name and address of parent	ho completed caus	e of death (It	om 23a) (Type	Print)		//	//	1/		0/	-0

Registrar
DHMH 17 Rev 1/2001

State

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	/Medic	al	4a. Facility Name (If not institution,			=011.0			Location of De	Februa		2008 County of Death	12:52A M
	Examin	er	7002 North Poin		,			lgeme			В	altimo	re Co.
	Funeral Director		5286ial Security Number 236-46-2941	6. Sex 1 □ M XX F	7. Age (In 74	yrs. last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 H Hours Mi		y, Year)	Coi	nplace (State or Foreign untry) th Carolina
			Usual Residence of Decedent			City, Town or Lo							10d. Inside City Limits
	/aryla	ō	10a. State 10b. County		100	. City, Town or Lo	Callon		T d a				1 ☐ Yes 2 ☒ No
	28a-	Director	Maryland Balt 10e. Street and Number	cimore			10f. Zip	Code	Eage	emere	10g. Citize	en of What Co	untry?
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<u>Ilan</u>	old be Jental rrked o	To Be	William Alonzo	Johnson	า				Mae	Burke			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Importent: If Item 27 is marked other then "naturet; or items 23e or 28e-f show eny injury or other traumatic event, the Modical Examinal must be notified at once.		19a. Informant's Name/Relationshi Kathy L. Bradle		ghter)		_			Rumi Route Numbe Dundalk,			Tip Code) 21222
ē,	f Heel Item 2 other		20a. Method of Disposition		20	b. Place of Dispo cemetery, crei	sition (Nan	ne of ther place	2/4	/2018	20c. Loca	ation - City or	Town, State
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Вох	eath certific ettending p I for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, ou 1☐Live	tcome of probirth 2		⊒Ectopic pr	egnancy			23	3d. Date of deli Month	ivery Day Year
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Sio	deeth ctor: /	icati	2 Accident investiga 3 ☐ Suicide 6 ☐ Could no	ot be One Dies	e of Injury -	At home, farm, str	M reet factors		′es 2 □ No	28f. Location (Street and	Number or Ru	ıral Route Number,
Ω	tal or A	Certification;	4 ☐ Homicide determin	build	ling, etc. (Sp.	pecify)				City or To	vn, State)		
	To the Hospital or Attending Physicien: The I within 24 hours efter deeth. To the Funeral Director: After this certiticate ha completely filled in by the funeral director, page	Medicai	29a. Certifier (Check only one) Curtifying 2 Medical E	xaminer: On the I	e best of my pasis of examiner stated.	knowledge feet mination and/or in	vestigation	at the tim , in my op	e, date and pla inion, death oc	ice, and due to the coursed at the time,	date and p	olace, and due	to the cause(s)
	Totl wihi Totl comp	Σ	29b. Signature, and title of certifier	Kon	lly	MA	- 1	: License		49		signed (Month	
	(o		30. Name and address of person w	no completed cau	se of death	(Item 23a) (Type,	Print)	- /	70000	200 H	70.7	71/	2008 more, Md
			31. Date filed (Month, Day, Year)	11/19/11/13	Registrar's S	CAST K	Olive	gu	1 USS PLU	iaus m	50/	DOITI	more, jud
	Sta Registr		FFR 0 5 20	08 /	A A	F FEETEN							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1108 P M Stephen F. Kraska 01-29-2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chespeake Hospital Bel Air Harford If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) DOD 11:08 pm 01/29/08 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ▼ M 2 □ F 213-36-6422 Director 66 08-10-1941 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U • S • A • 14. Race - American Indian, 1001 Apt D Jessica's Ct 21014 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Lucent Technologies Production Tech. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Walter Kraska Marie Arczynski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Leslie Klock (Daughter) 1001 Apt D Jessica's Ct BE1 Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 02-2-2008 Gardens of Faith Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -una Concer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: been signed by the attendin should be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Vital Records, 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has 1□ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 100 2 ER/Outpatient 3 DOA 1 🗔 Impatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No I or Attend after death Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours aft To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) guo, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) negapealle Dr.

State

Registrar

31. Date filed Month, Day, Year)

2008

05

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 6:30 P.M Tae Won Kim 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Harford 8. Date of Birth (Month, Day, 4/22/ 9. Birthplace (State or Foreign Country) South Korea 7. Age (In yrs. last birthday) Security Number **Funeral** Months Days 1 MM 2□ F 47 Yrs. 1960 220-06-9723 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at Maryland Harford Fallston 1 ☐ Yes 2 No Director 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number ms 23a or 7 9 fallston View Court 21047 Funeral America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Item 27 is marked other than "natural", or Items other traumatic event, the Medical Examiner mi Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√ZNo Korean Be Completed by 3 Widowed 4 Divorced 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) food service self employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental Yoo Sung Kim Suk Eun Jung ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Soon Hyun Kim/ wife 9 Fallston View Court Fallston, Maryland 21047 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February Department of Important: If It any injury or o of 1☐Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 4 □ Donation 5 □ Other (Specify) 5, 2008 Baltimore, Maryland 21. Signatur Fuperal Service 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A Timonium, Maryland 21093 2325 York Road Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 40 hvs **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine aw requires that the death certificate be executed burial-transi Due to (or nding physician ause as the burial-Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 □ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an certificate 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: / 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 500 Upper Chespeake Drive, mora rar's Signature 31. Date filed (Month, Day, 32. Red Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 **Physician** Edward Kellner РМ 2008 /Medical 7:00 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 □ F Hours Min. 93 Director 212-10-2043 1-26-1915 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shor r must be notified a Maryland Baltimore Sparks Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Rainflower Path #103 21152 U.S.A. by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14 Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any fijury or other traumatic event, the Medical Examiner Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: 3 ☐ Widowed 4 ☐ Divorced White Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice President - National Sales A/B Brewerv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be С. Albert Kellner В. Sadie Busch ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Kellner Same as #10a - #10f 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Oaklawn 2/5/08 Baltimore, Maryland 21. Signature of Furnital pervise Lice 22. Name and Address of Facility Ruck Towson Funeral Home, Ernest/L III 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a sense uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine One to for as a consumence of certificate be executed as the burial-transi aftending physician and Due to (of as a consequence of) Box 68760 Physician/Medical use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery lor 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown ρ signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 Yes 2 No 3 Probably 4 Donknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autonsy performed? certificate or Vital 1∐ Yes or Attending Physician; 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence မ 1 🔲 Yes 2 ER/Outpatient 1 🗀 Inpatient 3□ DOA 6 Other (Specify 28a. Date of Injury (Month, Day Year) 27. Manner of Beath 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1. Natural Injury 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) (James 58 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD EDDIE NAKHUDA, M.D. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State FEB 05 2008 Registrar

FEBRUARY

KELLNER

EDWARD

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** January 26. 9:15 P [№] 2008 L. Kelley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wilson Health Care Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 6, 9. Birthplace (State or Foreigr Country) West Virginia 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1930 Months 1 □ M 2 🖔 F Dec. 77 Yrs 235-44-6764 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10b. County or 28a-f show 1X Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 238 9208 Columbia Blvd. 20877 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iteme Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: if item 27 ie marked other than "any injury or other traumatic event, the Mar College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Layne Ruth Moore ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Kelley (Son) 9208 Columbia Blvd., Silver Spring, MD 20877 20b. Place of Disposition (Name of E1K H1111S 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-1-08 Charleston, WV 5 Other (Specify) Memorial Park 22. Name and Address of Facility Hafer Funeral Home 21. Signature of Funeral Service Licensee Money 50 N. Pinch Rd., Elkview, WV 25071 ennue Approximate Interval Between Anset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) months **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine sicien and requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Year Month Day 5 Other (specify) Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed •24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 11 2 No 1 Yes Division of Vital To the Hospitel or Attanding Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this c funeral dire Certification: To 1 [Innatient 2 FR/Outpatient 3FT DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: , completely tilled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 204115 201 RUSSELLAVEQUE CALITHERSBURG, MD 208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -BIRSCHBACH 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

08-00813 Jennifer Ballard Koch

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 02962

		1- For State Certificate of Death Reg. No.														
Physicia			2. Date								Date of De Month					
dical Exami		Jennifer Ballard Koch January 29, 2008											1433 hrs			
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location							ocation of	Death		4c.	4c. County of Death			
		4a. I acinty Name (il not included), give substant						Rock	K S			F	Frederick			
		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)			If Under 1 Year If Under 24Hrs.				8. Date of Birth (MM		M/DD/YYYY) 9. Birthplace (State or			
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after	by F	Widowed 4 Divorced If Yes, Give Year or Dates:					1 Yes 2X No specify:				-	The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon				
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-0C d wild gier ther	Ş	17. Father's Name (First, Middle	e, Last)					1	8.Mother's	s Name (l	First, Middle	e, Maiden	Surname)			
15 File al Hy edo	Be	Ian Matheson Ballard					Paula			a St	aples				_	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	10 B	19a. Informant's Name/Relation	ship (Type, F	Print)	19	b. Mailin	g Address	(Street	and Num	ber or Ru	ral Route N	lumber, C	City or Town,	, State, 2	Zip Code)	
D Shou shou and P 7 is r	-	Henry T. Koch			1	5056	Doral	! P1	Н	avma	rket.	VA 2	20169			
MD nd 2 sho alth and m 27 is		20a. Method of Disposition	(nusi				sition (Name	_			Date		Location - 0	City or T	own, State	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or important or other trannatic event, the Medical Examiner minury or other trannatic event, the Medical Examiner man		1 Burial 2 XCrematic	on 3 Re	emoval from Sta	. crema	tory or ot	her place)				1 00		1	1	77 A	
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Dep Dern		P.D. Roy I.63 Middleburg, VA 2011										18				
Physician	┢┈	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and														
/Wedical		failure. List only one caus	e on each lin	e.											Death	
aminer		Immediate Cause (Final diseas or condition resulting in death)		iple Injuries	augus of):			_						\neg		
		or condition resulting in death) Due to (or as a consequence of):														
	<u></u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):														
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376 ficat g ph	≧	23b. Was decedent pregnant in	the se	Live birth	no or program		etal death	3	Ectopi	c pregnar	псу		Month	D	ay Year	
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Box 68 e death certi the attending ed for use as	Si	1 Yes 2 No 9 ✔ U	nknown g	Unknown				_								
, P.O. Box 687 rres that the death certifi signed by the attending the detached for use as it.	Phy	Part II. Other significant cond	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions													
P.O.	\$								1 Yes 2 No 3 Probably 4 V Unknown							
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tal ician icert cert	8	examiner?	Hospi	tal:	ent 2 ER/	Outpatier	nt 3 D	OA	Other ₄	Nursin	g Home 5	Resi	dence 6	Other	: Scene	
Phys rthis	2			28a. Date of Inju		o. Time of			iry at Wor	k2	28d Descr	ibe how i	njury occurr	red		
Afte funes	=	27. Manner of Death 1 Natural 5 Death		Jan 29, 2008		20 hrs	,,	_		=	Subject o	driver o	f vehicle	in veh	nicular accident	
ior tend leath. tor:	₩	2 Accident	Periodic							28f. Location (Street and Number or Rural Route Number, City						
Division of Vital Records, tal or Attending Physician: The law require as after death. In pirector: After this certificate has been siled in by the funeral director, page 2 should be led in by the funeral director, page 2 should be		28e Place of Injury - At home, farm, street, factory, office building, etc. 20							28f. Location (Street and Number of Rural Route Number, City or Town, State) Route 15 at Route 464, Point of Rocks, MD							
ital Oil	Certification	Suicide determined (Specify) Major Road / Highway Route 15 a								at Route						
Hosp 4 ho Fune														ed.		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached fro use as the burial - transit	2	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due										due to th	ie cause(s)			
To To	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signature and title of certifier										ed (Month, Day, Year)				
	-	OCME O.C.M.E.								nc.	January 30, 2008					
		1 Sundry	M.	King	1 JM	lon	2						, , , , , , , , , , , , , , , , , , , ,			
70. Nan e and address of person who completed cause of learn (Item 23/) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201																
4		Theodore M. King,	Jr., MD.			miner	11176	ain 2	ueet, B	aitiiiiiiii	e, IVID 2 I	201				
售	Stat	31. Date filed (Month, Day, Yea		32 Registra	ar's Signature	dis	A 8									
Regi			2008	Page Car	1 200	1	100									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02963 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death v 30, 2:33P M THERESA CHRISTINE KRAMER 2008 January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER OF BALTO, HOSPICE Baltimore County Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y May 22, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□M 2XF Months Days Hours Min. 074-18-0537 82 May New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 Dulaney Valley Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify 3 ☐ Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical Services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bronislaw (Benjamin) Zemak Alexandra Kagznaczyk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pricscilla Connolly (Daughter) 11412 Mays Chapel Road, Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb 2, 2008 Timonium, Maryland 21. Signature of Funeral Service Liber ee Martin D. Lawson 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
Maryland 21212 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA DAYS Due to (or as a consequence of): PARKINSONS DISEASE Sequentially list conditions,

Physician /Medical Examiner

Department of Health and Mental Hygis Important; if item 27 is marked other i any injury or other traumatic event, tt once.

Physician

/Medical

Examiner

Directo

Funeral

9

Completed

Be

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

physician and s the burial-trans

after death

To the Hospital within 24 hours a To the Funeral I

Records,

Examiner Physician/Medical Completed by Certification: To Be

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				17				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ To 9 □ Unknown	23d. Date of delive	ery Day Year								
Part II. Other significant conditions con	ntributing to death but not res	ulting in the underlying	cause given in Part I.		o use contribute to t 2 ☐ No 3 ☐ Prot	he cause of death?				
				24a. Was an autopsy performed? 1 Yes 2	prior to co death?	opsy findings available impletion of cause of 2 No				
25. Was case referred to medical examiner?	26. Place of Death Check onl one)									
1 ☐ Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ I	OOA Other: 4 Nursing I	Home 5 ☐ Residence	6 Other (Special	HOSPICE				
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj						
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factory)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

064395

JANHARY 30, 2008

son who completed cause of death (Item 23a) (Type, Print)

6565 N. CHARLES ST. SUITE 209 BALTIMORE, MD 21204 DANIEUE DOBERMAN, MO

State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g876 2-7-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Kellam Month **Physician** 21:05 akita February 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Baltimore Johns Hopkins Bayview Medical Center 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 □ F Months 219 88 8355 32 Director MD. Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eaith and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County N/A BALTIMORE "natural", or items 23a or 28a-f sh dical Examiner must be notified MD. 1XIYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 518 ROBERTSON ST. 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ You Specify: Baltimore, Maryland 21215-0036 BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 77 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH NURSING ASSISTANT PRIVATE DUTY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES RANSON 2 GLORIA KELLAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a GLORIA KELLAM (mother) 518 ROBERTSON ST. BALTO, MD. 21205 or other permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of Mt. cerzebon crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1√ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (*Specify*) 3 Removal from State TRINITY FEB.12,2008 BALTO,MD. -CEM. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused be reath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21213 Approximate Interval Between Onset and Death Immediate Cause (Final Aivum Complex Infection **Physician** Mycobacterium 9 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Immunodeficiency Virus YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Wonknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has 1☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 3□ DOA 2 ER/Outpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manny of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day,

austa

DOK

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

32 Registrar's Signature

RES-000

29d. Date signed (Month, Day, Year)

Februar

Avenue Baltimore, MD. 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 **Physician** Katharine Lemmerman M. February 2008 2:14 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 X F MAY 17 1919 88 Maryland 219-36-2007 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No MD **Baltimore Funeral Directo** Catonsville Katherine M. Lemmermen 2/2/08 Baltimore, Maryland 21215-0036 0214 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 119 Stonewall Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2 🛣 No Specify: þ 3 Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the once. 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Albert Hobson Madalene Phiffer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Lemmerman - daughter 140 Longview Drive, Catonsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery 2/6/2008 Baltimore, MD 21. Signature of Funeral Service License H. Williams MacNabb Funeral Home, P.A. 301 Frederick Road, Catonsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -VNG nowing comoun /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 120 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an certificate has be rector, page 2 s autopsy performed? 2 No 1☐ Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😿 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation thours after death. -uneral Director: A 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours at To the Funeral Completely filled it ★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier, 29c. License number

10

State Registrar

DHMH 17 Rev 1/2001

Var

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . CAMMUES

2008

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Registrar's Signature

6701

N. Charles ST PONSON MO 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 **Physician** Month Pamela Lou Leake 1131 M anuar /Medical 4a. Facility Name (If not institution, give street, and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Health If Under 1 Year | If Under 24 Hrs. N/A 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 216-78-6009 8. Date of Birth (Month, Day Yea Apr. 10, 6 Sex 7. Age (In yrs. last birthday) **Funeral** ^{Yea} 1960 Days 1 □ M 2 👿 F 47 Yrs. Director Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at Yes 2□No MD N/A Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2000 Deering Avenue 21230 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Evaniance. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Lee Kendall, Sr. Thelma Mae Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2000 Deering Avenue, Baltimore, MD 21230 19a Informant's Name/Relationship (Type. Print) Kevin Leake - Husband 20b. Place of Disposition (Name of LOCCON CIPMAN or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Paurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cemetery 2-4-2008 Baltimore, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 22. Name and Address of racing Ambrose runetations, 1328 Sulphur Spring Rd., Arbutus, MD 21227

Approximation as cardiac or respiratory arrest,

Approximation and Address of racing Ambrose runetations, 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiac Amy Minia Iminute /Medical Due to (or as a consequence of Examiner 30 minuto Sequentially list conditions, if any, bedding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months! 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Mypertension 1 Yes 2 No 3 Probably 4 Unknewn 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier BC9916795 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Checkley Soules Megnan 900 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 05 Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00828 State of Maryland / Department of Health and Mental Hygiene Benjamin L. Lyons 1- For State Certificate of Death Reg. No Registrar 3. Time of Deat 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 30, 2008 0650 hrs Lyons Medical Examiner Lewis Benjamin c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silver Spring 1231 Fidler Lane 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY) If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex **Funeral** oreign Country) MN Months Days Hours Oct 9, 1977 472-11-3948 1XM 30 Director 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Fargo ND Cass 28a-f shov it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hygene ortann: If item 27 is marked other than "natural", or items 23a or 28a-f she ry or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1002 43 1/2 Street South 58103 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Married Yes White Yes 2 X No specify: Specify: If Yes. Give Year Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 Retail Sales 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arlene Amundson Fred Lyons æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Westminster, CO 80234 11391 Navajo Circle Unit C Fred Lyons - Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place)
Brookfield
Crematory Burial 2 X Cremation 3 Removal from State permit. Page:
Department or
Important: I Brookfield, Colorado 2-5-08 Other Specify Donation 5 22. Name and Address of Facility 1998 W. 10th Ave. 21 Signature of Funeral Service Licenses Broomfield, CO 80020 Rundus Funeral Home Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician fallure. List only one cause on each line. 'Medical a. Hanging Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed cian/Medical tending physician are use as the burial -UNPENDED AMENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 후 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 ✔ No 3 Probably 4 Unknown ð ۵. Completed Records, 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy death? performed? After this certificate has ✓ Yes 2 1 🗸 26.Place of Death (Check only 25. Was case referred to medical Be Other₄ examiner? Residence 6 V Other: Scene ER/Outpatient 3 DOA Nursing Home 5 Inpatient 2 1 V Yes 28a. Date of Injury FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Subject hanged self FOUND: 1 ✔ Yes 2 Natural Pending 0615 hrs Jan 30, 2008 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗸 Suicide Could not be

the Hospital or Attending Physician: hin 24 hours after death. Division of Vital within 24 hours at To the Funeral I

or Town, State) 1231 Fidler Lane, Silver Spring, MD determined (Specify) Other (const. site) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 30, 2008 O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Tasha Greenberg MD.

111 Penn Street, Baltimore, MD 21201

Approximate Interval Between Onset and

Death

Year

31. Date filed (Month, Day, Year) State Registra

Registrar's Signature

cal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene #23e Per FH G876 2/21/08til Hate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Michael Theodore 7:45 P M Lapka January 28,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 609 South Oldham Street Baltimore City 8. Date of Birth (Month, Day, Year) OCt. 29,1929 if Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Hours Min Days 1X M 2 □ I Mary land Yrs 216-24-9707 78 Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location show ed at 10d. Inside City Limits a or 28a-f sho t be notified a 1X Yes 2 □ No Director Baltimore City N/A Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 3 ury or other traumatic event, the Medical Examiner must be no 21224 United States 609 South Oldham Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🖾 No Specify: Specify: White 3 Widowed 4 Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Forklift Operator Warehousing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Theodore Cecelia Fialkowska Lapka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Lapka (Wife) 609 South Oldham Street Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 2/1/2008 Middle River, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21222 km <u>7922 Wise Ave. Dundalk, Maryland</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Malignant **Physician** disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 9 Unknown ate has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2XXNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore

29c. License number

29d. Date signed (Month, Day, Year)

10 N Greene St, Baltimore MD 21201

32. Registrar's Signature 31. Date filed (Month, Day, Year) 2008 FEB 0 5

29b. Signature and title of certifier

			State of Maryland /	Depa	rtment of h	lealth and I	Mental Hy	/gien	е	
			1 State Registrar	Cer	tificate of	Death		Reg. N	0. 200	8 0296
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of D Month		ay Year	3. Time of Death
	/Medic		William Thomas LeFave				Febru	ary	1, 2008	4:15 P ^M
ŀ	Examin	er	4a. Facility Name (If not institution, give street and number)			r Location of Death	1	4	c. County of Deat	
~	- 1		8200 Wisconsin Avenue, #611 5. Social Security Number 6. Sex 7. Age (In yrs. last b.	irthday)	Bethe If Under 1 Year	sda I If Under 24 Hrs.	8. Date of Bi	irth	Montgon	nery hplace (State or Foreign
	Funeral Director		030-32-1247 1∑M 2□F 64	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D December	ay, Yea r 27	1943 Mas	untry) sachusetts
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	arylan show	F	10a. State 10b. County 10c. City, Tov							10d. Inside City Limits
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	eath	eral	8200 Wisconsin Avenue, #611 11. Marital Status 12. Was Decedent Ever in U.S.	13 V	208 Vas Decedent of H		pacify Vac or N		ited Sta	
^	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Funeral	1 □ Never Married 2 Married Armed Forces? 1964-	. "	Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)	0-	Black, White	
2-0036	urs a al", o Exarr	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1970	1	☐ Yes 2∏ No	Specify:			Specify:	White
<u>ဂ</u>	72 ho natur lical	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	a. Deced	ent's Usual Occup	ation during most of wor	kina	16b.	Kind of Business/	Industry
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yiana	l be fi ntal H ed otl	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nan		e, Maide	n Surname)	
<u> </u>	hould d Me mark matic	ျှ	Walter LeFave 19a. Informant's Name/Relationship (Type. Print) 19	h Mailin	g Address (Street		McIsaac	hor City	or Town State 3	Zin Coda)
2	d 2 s Ith an 27 is trau									aryland 20814
a)	s 1 ar f Hea tem 2				sition (Name of natory or other place		Date		Location - City or	
2	Pages ent or tt: If i				tional Ceme			Tr	iangle.	Virginia
Daltillion	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatuje of Fun ry Service Licensee	Rol	Name and Addre	ss of Facility Tiphrey Fund	eral Home	/Betl	nesda-Chev	y Chase, Inc.
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	¥	ill	23a. art. Inter the disease, complications that caused the death. Do shock or heart failure. List only one cause on each line.			ng, such as cardiad	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition a. Coronary Hear		sease					
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5	e exe	Ex	resulting in death) Last Due to (or as a consequence	of):						
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Š	ertific ling p	Med	IF FEMALE:			-				
מא	sician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? □ Use 1 □ Use 5 □ Use 5 □ Use 5 □ Use 5 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □ Use 6 □		Ectopic pregnancy	1			23d. Date of del Month	ivery Day Year
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2	ttend leath. tor: /	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 286 Place of injury. At home f	orm etre		Yes 2 ☐ No	00/ 1 !!	(0)		
5	or A	Certification:	4 ☐ Homicide determined 28e. Place of injury - At home, find the building, etc. (Specify)	am, sue	et, ractory, office		City or To			ıral Route Number,
	spital ours neral filled		29a. Certifier 1 💢 Certifying Physician: To the best of my knowledg	je, death	occurred at the tir	ne, date and place	and due to the	e cause(s) and manner as	stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	ind/or inv	estigation, in my o	pinion, death occu	irred at the time	, date a	nd place, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. D	ate signed (Mont	h, Day, Year)
ı			In Chandhress	mo	D00	14364		Feb	ruary 4	, 2008
	'UX,		30. Name and address of person who completed cause of death (tern 23a)		•					
	10		Mohammad H. Chaudhry, M.D. 7610 (Carr	olļ Avenu	ie, Takon	a Park,	Ma	ryland 2	0912
	Sta Registr		31. Date filed (Month, Day, Year) 2008 32. Registrar's Signature		The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #8, perFH.g876, 2/5/08 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Little azmine 31 1:59 AM anvary 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 4c. County of Death Workins Johns 1+im N/AIf Unde 8. Date of Birth (Month, Day, Year) 1994
DEC. 10, 2008 5. Social Security Number 6. Sex 7. Age (In y If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 ☐ F Min. 215 43 4507 13 Director MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified at No 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2 iner must be no filed within 72 hours after death with 7116 MINNA ROAD 21207 Examiner must USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes ﴾ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specify: BLACK Specify by 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) BENNETT MIDDLE Elementary/Secondary (0-12) College (1-4or 5+) 7TH SCHOOL STUDENT Important: If item 27 is marked other any Injury or other traumatic event, if 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental RODNEY LITTLE (father) Tia Mc Carthy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RODNEY LITTLE (father) 916 GORSUCH AVE. BALTIMORE 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State **Department** 4 Donation 5 ☐ Other (Specify) LORRAINE PARK Feb. 7, 2008 BALTIMORE, MD. 21 Signature of Funeral Service Licensee 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal Cell Carcinoma 2mosThs /Medical Due to (or as a consequence of): Examiner Renal 2 Neeks tou lure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner plevial effusions law requires that the death certificate be executed metastatic 2 months and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 2 No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 1 No 1 (4) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Res-000 anvans

State Registrar 30. Name and address of

31. Date filed (Month, Day,

FEB

erson who completed o

rettes

Year)

Wolfe Street Baltimore

ge of eath (Item 23a) (Type, Print)

600

32. Registrar's Signature

08-00892 ΕII

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 02971

lery George M	•	- For State Of Maryland / Department of Fleath and Certificate of Death	Reg.	
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last) Ellery George Mickel	2. Date of Death Month February 1,	Day Year 0805 hrs
ledical Exami		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lo		4c. County of Death
		204 Red Lion Branch Road Millington	If Under 24Hrs. 8. Date of Birth	Queen Anne's (MM/DD/YYYY) 9. Birthplace (State or
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 212-92-5774 1X M 2 F 42 Yrs. If Under 1 Year 42 Yrs.		7, 1965 Foreign Kansas
any		Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limit
* *	٦	Maryland Baltimore Halethorpe		1 Yes 2 X
Maryland - 28a-f show	Director	10e. Street and Number 10f. Zip Code 20.3 //th Assemble 21.227	100	g. Citizen of What Country? USA
ath with the Mary items 23a or 28a ist be notified at		203 4th Avenue	anic Origin? (Specify Yes or No-	14. Race - American Indian, Black,
5-0036 led within 72 hours after death with the Maryland bygene. other than "natural", or items 23a or 28a-f sho	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban,	Mexican, Puerto Rican, etc.)	White, etc.
after d al", or	by Fi	3 Widowed 4 Divorced If Yes, Give Year or Dates:	_	Specify: White 16b. Kind of Business/Industry
hours natur Exam	ted t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)	DO NOT use retired)	
36 thin 72 ne. than '	ompleted	11 Carpenter		Warehouse
21215-00 uld be filed wit Mental Hygien marked other c event, the M	Cor	17. Father 5 Name (First, Middle, Last)	8.Mother's Name (First, Middle, M Frances L. (
2121 2121 ould be fi Mental marked	o Be	Howard A. Mickel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street	and Number or Rural Route Numb	ber, City or Town, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: I friem 27 is marked other than "natural"; injury or other trannatic event, the Modical Examiner:	-	Evan Mickel, Brother 4 Broadridge	Lane Lutherville	e, Maryland 21093 20c. Location - City or Town, State
re, restrand		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cen crematory or other place)	,,	
Baltimore, permit. Pages I at Department of Hee Important: If ite		4 Donation 5 Other Specify: Metro Crematory 1	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	Baltimore, Maryland
Balt permit Depart Impor		21. Sign_tur Funeral Service Licensee Thomas Gregor Thomas Gregor 22. Name and Address Cremation 299 Frede	Society Of Mar rick Road Balti	yland, Inc more, Maryland 21228
Physiciar	_	23a. Part I. Enter the disease, or complict flors that caused the death. Do not enter the mode of dying, failure. List only one cause on each line.	such as cardiac or respiratory arre	est, shock, or heart Approximate Inter Between Onset a
Vedica amine		Immediate Cause (Final disease a. Cardionegaly		Death
		or condition resulting in death) Due to (or as a consequence of):		
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause		
de	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
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60, ate be execut hysician and burial - tran	edic	X UNPENDED AMENDED		23d. Date of delivery
1876 rtificate ing phy	Physician/Medical	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3	Ectopic pregnancy	Month Day Year
OX 6	Sici	past 12 months: 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown		
Division of Vital Records, P.O. Box 6876 tall or attending Physician: The law requires that the death certifica its after death. The proceed of the proceeding of the proceed of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the proc	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	,	bacco use contribute to the cause of death?
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of Vital Records ing Physician: The law requi	niled in by the functal director, page 2 should Certification: To Be Complete	1 V Yes 2 No 27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury		how injury occurred
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E 5 5			ate and place, and due to the cau	se(s) and manner as stated.
o the H ithin 24	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinio and manner stated.	n, death occurred at the time, date	and place, and due to the cause(s)
F 3 F	§ §		se number .M.E.	29d. Date signed (Month, Day, Year) February 2, 2008
N W	5	largente the Trule		. 05/00/, 2, 2000
Das		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, E	Baltimore, MD 21201	
`	Stat	31. Date filed (Month, Day, Year)		
Red		B E 71818 1 220000000000000000000000000000000		

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	J. Donar	-		(h.r.di

State of Maryland / Department of Health and Mental Hygiene UU 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HARRY **Physician** Year MARTINDALE FEBRUMA 6:00 AM /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Glen Burnie Anne Arundel Glen Burnie Health & Rehabilitation 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) JAN 18 1921 **Funeral** 9. Birthplace (State or Foreign 1**X** M 2□ F Days Hours 218-03-1574 Director Yrs. 87 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show of Health and Mental Hygiene. Item 23 or 28e-1 show other treums 13a or 28e-1 show other treumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7355 Furnace Branch Road 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 Yes 2X No 3 XWidowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Factory Worker Aluminum 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be in nent of Health and Mental I Allen Martindale Elizabeth Pikie Edgar Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey M. Martindale - daughter 1833 S. Charles Street, Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State = 5 Department of Importent: If any injury or once. Metro Crematory, Inc. 2/4/2008 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenseen H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Filysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknows Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an EMENTA 2 X No 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Medical Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director; the 6 Could not be 3 T Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ro the 29b. Signature and title of certified 29c. License number D-22609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRANCH Rd GLEN 7445 FURNACE 31. Date filed (Month, Day, Yeer) 32 Registrar's Signatu State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** MILLER FEBRUARY FRANCES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON MANURCARE BOLTIMURE if Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Year) 1 □ M 2 F 166-20-094 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ber 21234 "natural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was De edent Ever in U.S. 11. Marital Status Armed Forces Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SICOL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Kd Tark ville 20a. Method of Disposition 10 Burial 2—Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If Ite any Injury or ot once, Valley Mem. Goodens 108 21. Signature of Funeral Service Licensee nd Address of Facility and Rd. Baltimore, Mo 21234 ACLI Evans Funeral Chapel- Cremation , or complication, that cause if the death. Do not enter the mode of dying, such as cardinc or respiratory arrest, list only $\frac{1}{2}$ cause on each line. 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final **Physician** DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? 1☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1□ Yes 214 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 1 ☑ Natural 5 ☐ Pending investigation 1 🗌 Yes after death. 2 Accident the 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 057722 MP 2008 FEBRUARY 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year

2008

Black, White, etc.

4:10 A

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10d. Inside City Limits 1 ☐ Yes 2 thNo

Birthplace (State or Foreign
 Country)

Services Parkville

Dav

MD

21208

Year

Month

Approximate Interval Between Onset and Death

10 State

Medical

31. Date filed (Month, Day, Year)

LEUNANS RICHARDSON

FEB 05

1838 GREEPE TREE ROAP #300 PIKESVILLE 32. Registrar's Signature 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.P.

Registrar DHMH 17 Rev 1/2001

_			1 - State Registrar	e of Marylan		artment of F ctificate of a		-	giene Reg. No. 2	008	0297
Physicia /Medica Examina			1. Decedent's Name <i>(First, Middle, Last)</i> Emmett Franci	s McGee,	Sr.			2. Date of De Februa		ටර්ෂ් ^r	3. Time of Death 12:15 рм
0			4a. Facility Name (If not institution, give street an Stella Maris	d number)		4b. City, Town, or	r Location of Death JM		4c. County Balt	of Death i more	
	Funeral Director		5. Social Security Number 213-34-5860 6. Sex 1 M 2	7. Age (In yrs. 71	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Pay, Year) 9. I			olace (State or Foreign
	the Maryland 28a-f show notified at	Director	Usual Residence of Decedent		y, Town or Lo	cation			10g. Citizen of V		0d. Inside City Limits 1 ☐ Yes 2 🕱 No
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р•ш•	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married 1 1 If Ye	Decedent Ever in U. ed Forces? Yes 2∐ No s, Give or Dates:	ŀ	Vas Decedent of H f Yes, specify Cuba I □ Yes 2X No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Blac	e - Americ k, White, Whit	etc.
12:15 p. 21215-0036	d within 72 ho giene. Ir than "natu the Medical	Completed		eted) ege (1-4or 5+) +1	16a. Deced (Give life. E Brok		ation during most of work I)	ing	16b. Kind of Bu		dustry
3, 2008 Maryland	should be file and Mental Hy marked othe umatic event,	To Be C	17. Father's Name (<i>First, Middle, Last</i>) Emmett A. McGee			:	18. Mother's Name Eleanor	Flynn		ne)	
• •	and 2 sho ealth and I n 27 is ma ier trauma		19a. Informant's Name/Relationship <i>(Type. Print</i> Mr. Timothy McGee/ Son)			and Number or Run nor Rd. P				Code)
FEBRUARY Baltimore,	Pages 1 ment of He ant: If Iten ury or oth		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)	from State C	emetery, cien y Cros	sition (Name of natory or other place s Cemeter	ry 2-9-		20c. Location -	-	
FEBR Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Licenses	4	22	Name and Address RUCK To 1050 Yo	öwsön Fun ork Rd. T	eral Ho owson,	me Inc Md: 212	0 4	
•	Physician /Medical Examiner	ner	Sequentially list conditions b.	that caused the death on each line to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as	uence of):	er the mode of dyin	g, such as cardiac	or respiratory ar	rrest,		Approximate Interval Between Onset and Death
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Ö	spital or hours afte ineral Dir y filled in		29a. Certifier 117 Certifying Physician: T	o the best of my know	wledge death	occurred at the tin	ne, date and place,	City or Tow	cause(s) and ma	nner as si	tated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only one) 2 Medical Examiner: On and 29b. Signature and title of certifier	the basis of examinal manner stated.	tion and/or inv	29c. License			date and place, 29d. Date signed	d (Month,	
	1401		30. Name and address of person who completed			•					
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Registrar DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Gordon Edward Miles, Sr. February 2008 /Medical 6:01am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Ruxton Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Director 214-14-8122 86 Dec. 13, 1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d, Inside City Limits 28a-f show must be notified at 1 □ Yes 2 □ No Director Marvland Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 6608 Kenwood Ave. 21237 United States Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify þ 3 Widowed 4 ☐ Divorced WW II 'natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 years n/a Forklift Operator Bell Systems Health and Mental Hygidem 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Miles ပ Addie Spurry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other tra once. Joan M. Sullivan (daughter) 105 Skyview Drive Shewsbury, PA 17361 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemtery 2-5-2008 Brooklyn Park, MD une di Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, 237 E. Patapsco Ave. Baltimoré, Wayne Osterling 23a Part1. Enter V shock, or hea ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause IF Physician tenoscleidir years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of): Examiner the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? División or Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a, Was an 1□ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 🗌 No after death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00 who completed cause of death (Item 23a) (Type, Print) MD. 6565N. Charles St 32 Registrar's Signa 31. Date filed (Month, Day, Year) State 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2115 AM Jean R. Moravec January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Baltimore Roland Park Place Nursing Center N/A . Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6-4-1907 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2KX 090-36-7182 100 Director Nebraska Usual Residence of Decedent 10b. Counfy 10c. City, Town or Location 28a-f show notified at 10a. State 10d. Inside City Limits Director 1 Xes 2 No Maryland N/A Baltimore the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? l or 830 W. 40th Street 21211 USA ns 23a (must b by Funeral ıral", or items 2 I Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes **XX**No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes XXX No Specify: 3℃Widowed 4 □ Divorced white natural Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) nt of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the M Central City Schools Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Ross Maude Scott ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (son) 1400 Lancaster Street Apt. 605 Baltimore, MD 21231 Dr. Clayton L. Moravec, Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State Department of Important: If any Injury or once. Metro Crematory 1/31/2008 Catonsville, Maryland 4 Donation 5 Other (Specify) 21. Signator Funeral Servide Livensee Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only directable on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hysician Stage dementia, unspecifica ears /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a consequence of) Examiner burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 □ Ectopic pregnancy Month Day Year 5 Other (specify) ed by the a detached t 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 icate has been sig , page 2 should b 034eoperosis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1□ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2[1] No 1 Inpatient 2 ER/Outpatient 3 DOA this 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation To the Hospital or Attendia within 24 hours after death. To the Funeral Director; Ai completely filled in by the fu death. 1 TYes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 113657 Tanuary 29, 2008 Greener 20

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIDEERETOR

ORIGINAL

TEOW 40th STREET, BALTIMARE, MD 21211

DHMH 17 Rev 1/2001

Registrar

		For State Registrar	State of Marylan	d / Depa		Health and N	lental Hy	•	02978
Physici /Medi		1. Decedent's Name (First, Middle, Li	Hildegard K	. Magr	ogan		2. Date of De Month Februa:		3. Time of Death 12:55 PM
Examir		4a. Facility Name (If not institution, gi Greater Baltimor		er		or Location of Death		4c. County of De Baltimo	
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20		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)	1P 212	04	~ >	<u> </u>
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 100 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** McKenzie 0830 AM Sobert L. 01 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CITY BAUTIMORR BALTIMORE JOHNS HOPKINS MOSPITAL Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Days Hours 1 X M 2 □ F 220-82-2145 46 June 18,1961 Director Maryland Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10b. County r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 1751 Burnham Road 21222 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 0 Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Years Carpenter Construction it of Health and Mental Hyg If item 27 Is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Lee McKenzie Anna T. Klosterman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Georgiann Capsey (Sister) 1750 Burnham Road Dundalk, Maryland 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 5 Other (Specify) Entombrent Molly Hill Mem. Gdns. 2/4/2008 Middle River, MD 4 Donation 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. ral Service Lic 21. Sign yure of F 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician archomysputh 1990 /Medical Due to (or as a consequence of) Examiner 19804 2006 Radacena Valve Harte Samentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit 1980 Discose Rhait tic Herrt Due to (or as a consequence of) Box 68760. physicien use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy ţō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown á 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No certificate Yes 2 No 1 Yes funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ER/Outpatient Certification: To 3 DOA 28b. Time of Injury 27. Manner of Death

1 Natural
2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 02/01/2008 REFUOO MD 4 30. Name and address of p son who completed cause of death (Item 23a) (Type, Print) GOD N Wolk St Bultwork, MD MD Johns Hopkins Happital

State Registrar

DHMH 17 Rev 1/200

Autur 31. Date filed (Month, Day, Year)

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ORIGINAL

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year Frank Mayeski, Jr. /Medical 2008 12:30A January 31, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 614 Waterview Drive Curtis Bay Anne Arundel Co. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☑ M 2 ☐ F Director 70 213-32-9136 July 17,1937 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland Anne Arundel Curtis Bay 1 ☐ Yes 2 ☑No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 614 Waterview Drive 21226 United States Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White er than "natura", the Medical I Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Maryland Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. 12 Years <u>Maintenance</u> Transportation Auth. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ukn. 2 Frank Mayeski, Sr. Dorothy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Theresa Mayeski (Wife) 614 Waterview Drive Curtis Bay, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; if ite
any Injury or ot 1 ☐ Burial 2 ☼ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 ☐ Doriation / Hix1top Service Corp. 2/5/2008 Towson, Maryland 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Melastatic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or derlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vitál Records, P.O. Box 68760, Physician/Medical as attending properties of use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy
performed

Ves 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 ☐ Nursing Home 5 1 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending Patter death. 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral [To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of-certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

TSO MD

31. Date filed (Month, Day, Year)

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

838 N. EutawSf Baltimore

		1	For State Registrar	State of Ma	-	epartm Certific			nd Me		iene g. No2	0.8	02981
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the Maryland			MD 10b. County MD Anne An	cundel	10c. City, Town	en Bur	nie Zip Code			11	0g. Citizen of	What Cou	10d. Inside City Limits 1 ☐ Yes 2 🖾 No Intry?
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Maryland 2121 de Should be filed within the nad Mental Hygiene. The marked other then traumatic event.	0	0 00	17. Father's Name (First, Middle, Last) John NMN McCormic 19a. Informant's Name/Relationship (Ty		105.3	- Adding Adding	(\$2	Ma	ry E	First, Middle, M	n		
Baltimore, Mar permit. Pages 1 and 2 st Department of Health and Important: If item 27 ler any injury or other traum		-	Mr. Jerry McCormic 20a. Method of Disposition 1 28 Burial 2 Cremation 3 CF	k / son	204 20b. Place of C cemetery,	Kuet	he Roa Name of or other place	ad; Gl	en B		MD 210 20c. Location	60 - City or T	own, State
Baltimore, permit. Pages 1 a Department of Hee Important: If item	once.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Vincen	Glen Ha	22. Name	and Addres	s of Facility	Sing	leton F	uneral	& C1	e, MD cemation ID 21061
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year Frank Novak EBRUARY 2008 8:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1 X M 2 □ F Director 215-14-9131 86 02-04-1921 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or "natural", or Items 23a dical Examiner must I 110 Royal Oak Dr. Unit H 21015 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status Black, White, etc. V Yes 2 ∏ No Yes, Give 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. \$ Specify: 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Credit Manager Steel Company traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adam Novak Bertha Kelly ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 Is Richard Novak (Son) 1330 Kings Lynn Ct Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or of once, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gar. 102-07-2008 Bel Air, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Eugeral Services 610 W. MacPhail Rd. Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of) Examiner ACUTE MYOCARDIAL INFARCTION Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed attending physician and for use as the burial-tran CORONARY ARTERY DISEASE Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ ACUTE RENAL FAILURE 1 ☐ Yes 🗽 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy perform certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 1 Depatient ို 2 ER/Outpatient 3 DOA this 27. Maprier of Dealt 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Certification: Natural (Month, Day Year) 5 Pending investigation 2 Accident 1 Yes 2 No completely filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jelou, M. D DØØ17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDALLAH J. H. 31. Date filed (Month, Day, Year) FEB 0 5 7601 OSLER DRIVE HELO TOWSON. MARYLAND 21204 32. Registrar's Signature State 2008 Registrar

			1 For State Registrar	State of Marylan		artment of F rtificate of		-	7 2 0	0.8	02983
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	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	Funeral		Was Decedent Ever in U. Armed Forces?	S. 13. \		lispanic Origin? (Spo an, Mexican, Puerto	ecify Yes or No		e - Americ	
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type.	•			and Number or Rura				Code)
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altimore,	Page ment o ant; If ury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (<i>Specify</i>)	oval from State		natory or other place ervice Co	orp. 2/7/0	08	Towson	Mary	vland
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Вох	res that the death certi igned by the attending be detached for use a	Physician/M	23b. Was decedent pregnant	If yes, outcome pf pregnar		Ectopic pregnancy	,			e of delive	*
	the deach the at	ysici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of de 9□Unknown		Other (specify)			Mo	nth	Day Year
, P.O	s that t ned by e detac	by Ph	Part II. Other significant conditions contrib	uting to death but not resu	Iting in the un	derlying cause giv	en in Part I.	23e. Did to	obacco use conti	ibute to th	ne cause of death?
Sign	w require been sig should b	ted b	Circhosis	liver				1 X	(es 2 □ No	3☐ Prob	ably 4 □Unknown
Vital Records,	has be	Completed						24a. Was	osy p	prior to con	psy findings available npletion of cause of
la I			25. Was case referred to medical				00 81(8 11	1□ Yes	2 X No 1	death? □ Yes	200
	hysicia nis cer direct	To Be	examiner? 1 ☐ Yes 2 No Hosp	oital: 1	======================================	t 3□ DOA Oth	_26. Place of Death er: 4 ☐ Nursing Hor	15. 0	<i>ine)</i> dence 6 □Oth	er (Specify	
Division or	ding Phys h. After this funeral dir		1 Natural 5 ☐ Pending	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Worl		28d. Describe I	now injury occurr	ed	<u></u>
/ISIC	or Attendate death Director: In by the	ficat	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 2	8e. Place of injury At hor	me, farm, stre		Yes 2 □ No	28f. Location (S	Street and Numb	er or Rura	l Route Number.
ā	ital or A rs after ral Dire led in by	Certification:	4 Li Milliolde	building, etc. (Specify				City or Tow	vn, State)		
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to make the funeral director.	Medical	29a. Certifier (Check only one) Certifying Physicia 2 Medical Examiner:	an: To the best of my know On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the ting estigation, in my o	ne, date and place, pinion, death occurr	and due to the ed at the time,	cause(s) and ma date and place,	nner as sta	ated. the cause(s)
	To the within To the Comple	Mec	29b. Signature and title of certifier	and manner stated.		29c. License			29d. Date signed		
)	n		19WW	-MD		22	0517		2/4	108	
			30. Name and address of person who compl	eted cause of death (Item	23a) (Type, F	J. Roll	inc R	D Ba	2/4 12 CON	1-6	22-8
	Sta	е	31. Date filed (Month, Day, Year)	32. Registrar's Signati			8				
	Registra	ar	FEB 0 5 200	1 1 10000	Ch ASS	15453					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 02^{Month} 02 2008 ear DOROTHY OTIS 5:00 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FOREST HILL HEALTH AND REHABILITATION FOREST HILL HARFORD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta Country) March 26,1916 New York **Funeral** Birthplace (State or Foreign Country) 1□ M 🐙 F Months Days Hours Min. 106-16-6850 91 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Framina. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NY Quoque 1 ☐ Yes 2 ☐ Nov Director Suffolk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 79 Old Depot Road 11959 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 XX10 1 ☐ Yes 2√√No þ Specify: 3 ₩idowed 4 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Αt Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be August Schmiemann ဥ Mary Garrecht 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Circle-Forest Hill, Maryland 21050 Ed Beck-son in law 20b. Place of Disposition (Name of cemetery crematory of other place)
EVANS FUNERAL CHAPTL AND 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XXX remation 3 ☐ Removal from State 2-4-08 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) CREMATION SERVICES BELAIR 22. Name and Address of Facility
EVANS FUNERAL CHAPEL
AND CREMATION SERVICES 21. Signature of Funeral Service Licenses 3 Newport Drive Forest Hill,MD 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** respe disease or condition resulting in death) /Medical Due to (or as a consequence o): Examiner rouble Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month 4□Pregnant at time of death 9□Unknown Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has certificate 2Q No 1 🗆 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No P 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attenc within 24 hours after death To the Funeral Director: 2 Accident filled in by the 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32275 Felun 4, 2003

State Registrar

31. Date filed (Month, Day, Year)

DR. DAVID DUNN

615 MACPHAIL ROAD

32. Projectrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pagistrar's Signature

BEL AIR, MD

21014

State of Maryland / Department of Health and Mental Hygiene 02985 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year LORRAINE OAKES FEB. 2, 2008 8:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL LUTHERAN VILLAGE WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 1 ☐ M 2 🔯 F 79 Yrs. Director 216-24-6583 3/26/1928 MARYLAND Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-f shot other traumstic event, the Medical Examinar must be notified at 1XYes 2 No Director CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 236 ST. MARK WAY USA s 1 and 2 should be filed within 72 hours after death v f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3℃ Widowed 4 □ Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES PERSON RETAIL 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FRANK JOSEPH HUDSON BERTHA ESTELLE STEINBACHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2689 DAY LILLY RUN, THE VILLAGES, FL 32162 WILLIAM LEROY OAKES -SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date permit. Pages 1
Depertment of H
Important: If Itel
any injury or oth 20c. Location - City or Town, State 1 Burial 2 Scremation 3 Removal from State ALL COUNTY CREMATION 2/4/08 SYKESVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 21. Signature of Enteral Service Licensee 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part 1. E the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** to thrive fallure disease or condition resulting in death) 6monles /Medical Due to (or as a consequence of): Examiner 6 Months Malnutrin Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á should I 3 Probably 4 □knknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 **⊡**-No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Universing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient this 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury death. investigation 1 Tyes 2 No Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 CO D52035 Westmus 7 30. Name and address of person who completed cause of death (Item 23a) (Tyge, Print) CHACKU Stoner Registrar's Signature 31. Date filed (Morth, Day, Year) State Registrar

			1 - For State Registrar	State of Maryla		artment rtificate			nd M		iene	008	02986
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	Funeral		Social Security Number 6. Se	7. Age (In y	rs. last birthday)	If Under	1 Year	If Under 2		8. Date of Birth (Month, Day,			lace (State or Foreign try)
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_		Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decede f Yes, speci	ent of His	spanic Origin, Mexican,	in? (Spe Puerto F	cify Yes or No- Rican, etc.)		Race - Americ	
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altimore	Pages ment of ant: If I		1 ☐ Burial 2 【XCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Me	etro Cre			,	/4/2	8008	Balti	more,	MD
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			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the de ne cause on each line.	ath. Do not ente	er the mode	of dying	, such as ca	ardiac or	respiratory arre	st,	,	Approximate Interval Between
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	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral	edical	29a. Certifier (Check only one) Certifying Physical Cambridge Check only	ician: To the best of my kr er. On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at estigation, in	t the time n my opir	, date and p nion, death	place, an	nd due to the cau d at the time, da	use(s) and r	manner as sta e, and due to	ited. the cause(s)
	To t To t		29b. Signature and title of eqrtifier	Brech	M.D	29c.	License I	number 369	740		d. Date sign	ned (Month, D	280 X
•	2041	1	30 Name and address of person who co	mpleted cause of death (Ite	em 23a) (Type, F	Print)	RF	RD	ME	MORAL	- 14	SPR	AL JOL
	Sta	e	31. Date filed (Month, Day, Year)	32. Modistrar's Sign	nature Sa	28H	UKI	ONA	REA	JUE H	WRE	DEC	PACE 2008
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No UU 1. Decedent's Name (First, Middle, Last) 2. Date of Death POWERS **Physician** Month 034 \M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Riva Terrace Assisted Living Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Feb. 18,1917 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2□F Months Hours Days 410-18-9622 Yrs Director Tennessee Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 211th Street 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 N/A <u>Acetylene Burner</u> Koppers Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 George Powers Lillie Gibson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Bothe (Daughter) 218 Baybourne Drive Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 □ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 02/06/08 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Chinz 3204 Mountain Road Pasadena, Maryland 21122 23a. Part* Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 3 W/S **Physician** disease or condition resulting in death) CUTE /Medical Due to (or as a consequence of): Examiner C RTERY ORONAM allen Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy signed by the atte Month 4☐Pregnant at time of death 5 Other (specify) 9 I laknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a, Was an autopsy performed? Yes 2 certificate 2 No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No 2 1 ☐ Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 6 Sother (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident in by the 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 0 5 FEB

Name and address of person

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

EFENSE HIGHWAY ANNAPOSMOLIYO

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 29, Nicholas John Pappas 12:50 P M January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Nursing Home Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 2, 1928 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 79 New Hampshire Director 002-12-8098 Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Institution it ferms 23a or 28a-f show any injury or other traumatic event, the Mudical Examinations must be notified at 10b. County 1 ☐ Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3310 North Leisure Blvd. #215 20906 United States Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give WWII/ Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 4 Auditor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be fi Theophanes Pappas Soltana Not Available £ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Andrew G. Pappas/Nephew 55 South Spring Street, Concord, NH 03301 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase. Inc. 7557 Wisconsin Ave. ° 4 ☐ Donation 5 ☐ Other (Specify) Cremătorium, 21. Signature of Funeral Service Licenses M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician End Stage Congestive Heart Failure 1 Month resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Years Sequentially list conditions, any learning to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Chronic Renal Failure 1 Month burial-tran that initiated events resulting in death) Last the ettending physician and Due to (or as a consequence of) Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Jo Month Day Year signed by the eld be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, should be 1 Yes 2 No 3 Probably 4 Unknown Renal Tumor of Uncertain Behavior Completed been 24b. Were autopsy findings available prior to completion of cause of death? Gout 24a. Was an this certificate has page 2 autopsy performed? 2□ No 1 ☐ Yes 2 🛱 No 1 Yes Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pendina 1 ☐ Yes 2 ☐ No death. М investigation 2 Accident filled in by the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after or To the Funerel Direct 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D00G1382 January 29, 2008 Thama 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shama Mittal, M.D. 14816 Physicians Lane, #152, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 05 FEB Registrar

DHMH 17 Rev 1/2001

P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #3, perMD,g876, 2/5/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 22,700g anidh /Medical 4a. Facility Name (If not institution, one street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Edyneu 6. Sex If Under 1 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** M 2□ F Director 357**-**42-5056 60 23, 1947 Ohio Usual Residence of Decedent 10c. City, Town or Location la or 28a-f show t be notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1408 Bonnett Place Unit K items 23a 21015 "natural", or items 23a USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ★ Married 1 TYYes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes A No Specify ģ Specify: 3 Widowed 4 Divorced Year or Dates: White Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Soldier U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore Randall Pryor Mildred Lucille Mabry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah A. Pryor / Wife 1408 Bonnett Place Unit K, Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Arlington Natl. Cem. 3-11-08 Arlington, Virginia 21. Signatur of Huneral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) rneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I signed by the a ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 4 Unknown 1 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No this certificate has ral director, page 2 autopsy performed? 2□No Yes or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA funeral Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury To the Hosphin...
within 24 hours after death.
To the Funeral Director: After 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) rson who completed cause of death (Item 23a) (Type, Print) Baltimore, mongland Brian Johns Bayview, 4940 Fastern Avenue 31. Date filed (Month, Day, Year) 32 Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

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			For State Registrar	State of Marylan		rtment of F		Mental Hy	giene Reg. No. 2	0.8	02990
, é.	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of D Month	640	Year	3. Time of Death
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	Funeral Director		5. Social Security Number 6. Sex 578 − 78 − 78 0 0	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Mir	8. Date of B (Month, D 0 7 - 2 3	rth ay, Year) -1956	Cour	place (State or Foreign atry) GINIA
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lar)	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	ľ	19a. Informant's Name/Relationship (Typ								Code) 20774
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Baltii	permit. Pages 1 Department of He Important: If iten any Injury or oth		21. Signature of Funeral Service License		22.	Name and Addre	ss of Facility RO	ONALD I	AYLOR,	II TMOR	FUNERAL H
1	3.3		23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the deat ne cause)on each line.							Approximate Interval Between Onset and Death
×-	Physician		Immediate Cause (Final disease or condition resulting in death)		Lesp.	ratory		luse _			Onset and Beaut
A.S.	/Medical Examiner		resulting in deathy	Due to (or as a conseq		tic	Enle.	phalo	Octobra		
¥.,	And Market	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	quence of):		Cite	p 11-10	vac i oi -		
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8760,	cate be executed oblysician and the burial-transit		resulting in death) Last	Due to (or as a conseq	quence of):						
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∕ita	Physician: The I this certificate har ral director, page	Be	25. Was case referred to medical examiner?	Hospital:		Oth		eath (Check only	one)		
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	ne Hospital 124 hours a ne Funeral I oletely filled	Medical (29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the tivestigation, in my	me, date and pla opinion, death oc	ce, and due to the curred at the time	e cause(s) and me, date and place	nanner as s , and due f	stated. to the cause(s)
	To the I within 2 To the complet	Ž	29b. Signature and title of Certifier		NU	29c. Licens			29d. Date sign	ed (Month,	, Day, Year)
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1	C		30. Name and address of person who co	mpleted cause of death (Iter	m 23a) (Type, I	Print) P 31186	ood Luck	Rd. Lan	ham, m	13,2	0707
500	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 5 2008	32. Registrar's Sign	ature	K)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend to tem at yard per per anner of TAB lift and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** SEWERYN PIASECKI JANUARY 7:25A 31 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ENGLISH GARDENS ASSISTED LIVING BALTIMORE N/A 8. Date of Birth (Month, Day, Year) 03/30/1911 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min POLAND 312-42-2963 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10c, City, Town or Location 10b. County 10d. Inside City Limits 28a-f show must be notified at 1 X Yes 2 □ No Completed by Funeral Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a 2600 GAGE COURT, APT. C 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No WHITE Specify. 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **ACCOUNTANT** ACCOUNTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HERCHEL HERSHEL **PIASECKI ESTHER** WEINTRAUB 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICE PRICE / NIECE 2172 STOWMONT COURT, DUBLIN, OH 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ■ Other (Specify) TIFERETH ISRAEL CONG. 02/03/2008 BALTIMORE, MD 4 □Donation 21. Signa 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or cor shock, or heart failure. List only caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** edate /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 Nother (Specify LIVING Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death. To the Funeral Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier leted cause of death (Item 23a) (Type, Print) address of 2835 Smith Ave BALT. MD 21209 MD (Month, Day, istrar's Signature 32. F Year) State Registrar

DHMH 17 Rev 1/2001

FEBRUARY

ELLEN QUINN

EDDIE NAKHUDA, M.D. 31. Date filed (Month,-Day, Year)

of certifie

Much

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title

2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 32. Restrar's Signature 2008

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

State of Maryland / Department of Health and Mental Hygiene

	1	For State Registrar	State of Maryla		ificate of D			eg. No.?	18 12993
Dhysioi		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	3. Time of Death
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Funeral Director		5. Social Security Number 6. Sex		rs. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, FEB 28	Year) 1919	9. Birthplace (State or Foreign Country) Maryland
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be be eve	To Be	Frederick Trib	111			Emma	Powell_		
Fe, Maryland s 1 and 2 should be file Health and Mental H tem 27 is marked oth	۲	19a. Informant's Name/Relationship (T)			g Address (Street a				State, Zip Code) 21045
		H. Mark Roth - so			Copper Sk				City or Town, State
		20a. Method of Disposition 1 ☐ Burial 2 反 Cremation 3 ☐ F			sition (Name of natory or other place				ore, MD
Baltimo permit. Page Department of Important: If any Injury or once.		4 □ Donation 5 □ Other (Specify,			matory, I				
Depart any l	١.,	21. Signature of Euneral Service Licens Steven 23a. Part1. Enter the disease, or compshock, or heart failure. List only or	W.	_ 9	Name and Addres remation 99 Freder	Society cick Road	oi Mary , Balti	more, M	Approximate Interval Between
Carrellon American Physician Physician and Physician and Physician and Street Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physician and Street Physicia	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the conditi	isequence of):					
Division or Vital Records, P.O. BOX 68, the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phympletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				ate of delivery onth Day Year
IS, F.	by	Part II. Other significant conditions of			nderlying cause give	en in Part I.			atribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
Division or Vital Records, if or Attending Physician: The law requires the death. Director: After this certificate has been signed in by the funeral director, page 2 should be to in by the funeral director, page 2 should be to	Completed						24a. Was autop perfo 1 Yes		Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
on or Vital Reduling Physician: The law n. After this certificate has funeral director, page 2	Be C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	ne)	
Of V Physic this ce al direc	To E	1 Yes 2 No		2 ER/Outpatien		4 Marsing Fi	ome 5 Resid		
On C		27. Manner of Death 1 ☐ Matural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Yea		Wor	k? Yes 2 □ No	Zou. Describe i	ion injury occu	
Divisio To the Hospital or Attend within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Certification:	2 Accident 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, str pecify)	reet, factory, office		28f. Location (\$ City or Tov	Street and Num wn, State)	aber or Rural Route Number,
Hospita 24 hours Funeral stely fillec	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my niner: On the basis of exa and manner stated.	amination and/or in	h occurred at the tin evestigation, in my o	me, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and n date and place	nanner as stated. e, and due to the cause(s)
To the be within 24 To the be completed	Me	29b. Signature and title of certifier			29c. Licens	e number			ed (Month, Day, Year)
		Mener Bo	wei ,	m	Day	377		2/3	108
10		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)	0 6-1-	0. 11.	2 .1.4 A	21228
S	tate	30. Name and address of person who Denear Bouling M 31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Aparts .	w, CA777		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1. 61

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February **Physician** Razgaitis Elsie 6:45 a ^M M. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 314 Whitaker Mill Road Fallston If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours MAR 10 1922 1 M 2X F 85 Pennsylvania Director 211-12-6966 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show be notified at 1 ☐Yes 2 No Director **Fallston** Harford 28a-f MD 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code or items 23a caminer must be 21047 USA 314 Whitaker Mill Road by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Examiner 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: "natural", 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed and Mental Hygiene.
is marked other than "natur
aumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Western Electric 10 **Assembler** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Baker Blair Burkhart Mary ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any Injury or other trau Alfred Razgaitis - husband 314 Whitaker Mill Road, Fallston, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 2/5/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature & Funeral Service Licensee Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 6Mas /Medical Due to (or as a consequence of): 2 Examiner Equalitially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): or Vital Records, P.O. Box 68760, attending physician for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an cate has I autopsy performed 2 NO funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 1 ☐ Yes 219110 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

After To the Hospital or Attending efter death. completely filled in by the within 24 hours a

(Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

and manner stated. 29b. Signature

16444

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

Atwood Road, Bel Air, MD Dr. Vijay Nair, 602 S.

Registrar

Medical

FEB 0 5 2008

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year Mary Schlorek Rahikka 31, 2008 4c. County of Death 1227M nuary /Medical 4a/ Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea/ July 22, 19 Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 🂢 F Yrs. **Director** 90 132-05-6595 Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b County 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2 No Baltimore Maryland Catonsville the 10e. Street and Number 10g. Citizen of What Country? "natural", or Items 23a or dical Examiner must be 21228 709 Maiden Choice Lane, RGT 302 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mathematician/Statistician Television/Advertising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental H Samson Adam Schlorek Helen Alexandria Zuk 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 la Robert Rahikka, Son 11869 New Country Lane Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State injury or permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 02/01/08 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PREUMONIA three Days disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð ustension Completed neec Decenditioning 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page 2 autopsy Fibrillabin 1∐ Yes 2 DH 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27 No 1 ☐ Yes r 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined lospital or A within 24 hours a To the Funeral D 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD B(99/6794 31 2000 1 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) South Caton 900 Baltmore Checkler Avent 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 10:05 AM Lloyd Reed /Medical D 2 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Good Eamaritan Hospita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10 30 45 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F Director 215-44-1521 62 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 1 XYes 2 ☐ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or ury or other traumatic event, the Medical Examiner must be 4705 Moravia Run Way 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? S . A 14. Race - American Indian, 21206 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: ρ 3 ☐ Widowed 4 💆 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12th Grade NA Postal Carrier Post Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wayne Reed Gertrude 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Reed-Daughter 20a. Method of Disposition 4705 Moravia Run Way Baltimore, MD 21206 ce of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 2/8/08 Owingsmills, MD 22. Name and Address of Facility March F/H East 21. Signature of Funeral Service Licenses 1101 E.North Ave Baltimore, MD 21202 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death contificate be executed ttending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year signed by the 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ metastasis Digbetis Hypirtaisin 1 Tes 2 No 3 Probably 4 Unknown Completed replacement 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an performed? Yes 2☑No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? after death. I Director: After to in by the funeral 28d. Describe how injury occurred Division the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I

State

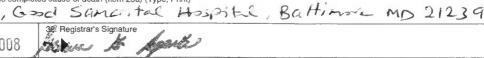
Amir Kazory 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

29a. Certifier

Medical

FEB 0 5 2008



M.D.

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

amend item 15 per fb 876 2-5-08 vt and Mental Hygiene Certificate of Death Reg. No. 🛴 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year Charles 21:29 M awrence 2008 FEB /Medical odriquez 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore If Under 1 Year If Under 24 Hrs. C000 SARRITAN HOSPITAL 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Min. 1 MM 2 □ F Yrs. Baltimore, MD 213-66-9678 Director 21,1956 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified Director 1 ☐ Yes 2 ☑ No Baltimore paltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or items 23a 8303 21234 Funeral vermont 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify. permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural"; any injury or other traumatic event, the Medical Exan 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+2 Elementary/Secondary (0-12) 12 sableo 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rodrique Baltimore MD 21234 Mark -brother 15 Havenheld D 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 12-1-08 Irarkulle 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
Approximation Services
Approximation Services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee May 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (TOTAL) CEREBELLAR SIROKE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (unas a consecuence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death Year 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPEXTENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy perform rmed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifie. 29c. License number MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 5601 21239 32. gistrar's Signature 31. Date filed (Month, Day, Year) State FEB 05 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division or Vital Records, P.O. Box 68760

Registrar

31. Date filed (Month, Day,

Year!

32. Registrar's Signature

10

State Registrar

31. Date filed (Month, Day, Year) **FEB 05** 2008



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** AM 2008 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** salt more ockeysvill Homes Masonia land If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days 1**™**M 2□F Yrs. 233-24-6670 88 21, 1919 WV Director Dec. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County itams 23a or 28a-f show 1 ☐ Yes 2 No MDBaltimore Cockeysville Direct 10g. Citizen of What Country? 10e. Street and Number 300 Interenational Cir. 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) p rmit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. In present if item 27 is marked other than "natural", or ital any njury or other traumatic event, the Nedical Eran a sal 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Service Station Entrepreneur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hubert Robertson Margie Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4766 Wellesly Dr. Woodbridge, VA 22192 Robert R. Robertson, Jr. Feb. 7, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Dulaney Valley 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specific Memorial Gardens of Ineral Service Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 W. Clary 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Cerebovasulan Accedent Immediate Cause (Final disease or condition resulting in death) Pnysician weeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the sequence of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit Exami attending physician and Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. hio NO CHE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2No 2 No 1 Tyes this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 1 Natural 5 Pending s after dec. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide Illed in by 4 Homicide 29a. Certifier Medical

Division of Vital Records, within 24 hours a

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2-3-08 Cult im 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 International Carelle LiBerto, Ms. 31. Date filed (Month, Day, FEB 32, Registrar's Signature Vear)

State Registrar

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